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**THE ATTITUDES TOWARDS AND EXPECTATIONS OF SOCIAL WORKERS IN
INTERPROFESSIONAL COLLABORATION FOR DISABLED CHILDREN:
FULFILLING SOCIAL WORK POTENTIAL**

BY

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A thesis presented for the Degree of Doctor of Philosophy

of the University of Wales

Date: 12th April 2002

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SUMMARY

This thesis argues that social workers have the potential to overcome weaknesses in practice and difficulties in collaboration in the field of child disability. The study examines the nature of the relationship between social workers and other professionals. It explores how difficulties affecting collaboration are constructed and maintained, and considers how they might be overcome.

The study explores the wide-ranging responsibilities that social workers carry for disabled children, and considers the particular importance of interprofessional collaboration and the social model of disability in their role. The thesis observes long-standing criticisms of social work practice in child disability work. Considering this, the adequacies of social work training and the place for specialisation in raising standards are explored.

The thesis examines the relevance of professional status in social work. This includes a discussion of that which characterises and constructs social work as a profession. The thesis explores how far a commitment to 'professionalism' is necessary for social work to fulfil its potential. Discussions highlight the inextricable links between social work's success in achieving professionalism and its relationship with employers.

The discussion of research methods explains how the questionnaire and semi-structured interview were selected as tools for gathering the opinions of a wide range of practitioners concerning social work practice.

The survey gathered the views of health and education professionals about the factors influencing their collaboration with social workers. Their opinions about social work competence in collaborative care planning for disabled children and families are discussed.

The views of social workers are also explored, concerning their own practice and the adequacy of their training in preparing them for interprofessional collaboration and their role in child disability work.

The survey provides insight into how the professionalism and potential of social work may be developed or restricted.

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted in candidature for any degree.

Signed..... (candidate)

Date..... *12th April 2002*

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated.

Other sources are acknowledged by footnotes giving explicit references. A bibliography is appended.

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I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

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Chapter 1 - Introduction

Building Relationships

This thesis examines the nature of the relationship between social workers and other professionals, with particular reference to collaborative working with disabled children. It explores how difficulties affecting collaboration are constructed and maintained, and considers how they might be overcome.

The importance of professionals working together in meeting the needs of disabled children has, in recent decades, been greatly emphasised by government and researchers; and the particular value of co-ordinated services for the parents of disabled children is now widely acknowledged (Browne 1982; McCarthy 1984; Evans et al.1986; Thompson 1986; DoH 1991a; BASW 1992c; JR Foundation 1994; Middleton 1996; Dale 1996; NAFW 2001).

The literature review undertaken as part of this study identifies how the needs of disabled children for diverse health, education and social services are best assessed, planned and met through different professionals collaborating with one another to achieve clear aims and objectives in their work. Thus, writers give particular weight to the necessity for all professionals to learn about each others' range of knowledge and skills, about their specific roles, and about how effective collaboration can be achieved.

The sum and substance of the burgeoning amount of writing on the subject of interprofessional working highlights the benefits for children of effective collaboration and co-ordination: it ensures that disabled children and families have all their needs identified and met; it is holistic; it minimises the sort of duplication and contradiction that can confuse the child and family; it facilitates a 'seamless service' - families are helped through the complex maze of

service provision which could otherwise appear disjointed and daunting - and all of this can help the child reach a fuller potential, and enable them and their family to be less disabled. In short, effective co-ordination and collaboration can have a significant impact upon the quality of the child's life.

There is a consensus in the literature, also reflected in legislation, that amongst all the professionals social workers are best placed, and most suitably qualified, to co-ordinate the assessment and planning process and to review and monitor the progress of the child's plan (DHSS 1971; DoH 1989; 1991a; BASW 1991b; NAFW 2001). The social worker's role in these matters is often assumed to be of central importance, and skilful collaboration with other professionals to be an integral and essential component of a satisfactory service. However, despite repeated calls for collaboration, there seem to be many difficulties that militate against it. Numerous reports expose apparent failures of social work in collaboration and in understanding and meeting the needs of disabled children (Browne 1982; Evans et al. 1986; DoH 1991b; Middleton 1996). Therefore, beneath the consensus about a preferred role for social work in bringing about collaboration between professionals, there is considerable doubt about whether social work in its present state can actually achieve this role.

The main thesis of this study is that social work does have the potential to overcome the difficulties of collaboration and its own weaknesses. However, this thesis will be examined critically. It will involve looking not only at the roles and assumptions of social workers themselves, but also at the views and opinions of social work among fellow professionals and practitioners (using work with disabled children as the main example). For social work's potential in interprofessional working to be realised, arguably certain conditions must be met and

specific difficulties overcome. Indeed if they are not, then the potential may be lost. These assertions are based on the hypotheses that:

1. Social workers are capable of addressing the weaknesses in their practice with disabled children and of overcoming difficulties in collaborative working. This requires a commitment to 'professionalism' though it is recognised that professional status or 'being professional' is at least partly about the relative success of an occupational group's claims to such status. Therefore a distinction is made, within this hypothesis, between the argument that (a) social work actually does have unique and appropriate skills with which to effect collaborative working, and to help clients such as disabled children in distinctive ways that other practitioners do not, and (b) that part of the task facing social work in such areas as work with disabled children is to claim to be the best qualified professional group to facilitate collaborative working, and to play a convincing and leading role in this. It is for the latter reason that other professionals' estimations of the work, role, training and status of social workers' skills and knowledge are a vital element in the study.
2. Social workers are capable of supplementing their existing range of knowledge and skills to meet the specific requirements of child disability work and interprofessional collaboration. For this to happen, however, they require opportunities to maximise their learning and practice in this field of work.
3. For practice weaknesses to be addressed social workers require structures, processes and resources from their agencies to support them in responding competently to the needs of disabled children and families.

Discussion of these hypotheses is intended to provide insight into the problems that prevent social workers from fulfilling their potential. To this end, the following questions are explored by the research:

1. What are the difficulties affecting collaborative working; why do they exist; how serious are they; how are they maintained; and how might they be overcome?
2. What knowledge, skills and values are required for social work with disabled children and families; is there adequate training available to equip social workers with these requirements; what difficulties do they have applying these requirements to their role; and how might these difficulties be overcome?
3. What organisational structures and resources do social workers need to support their role with disabled children; what prevents these from being available; and what can be done to secure them?

Searching for a Holy Grail

The study described here began nine years ago, and was prompted by the researcher's own social work practice with disabled children. Over the years, a comprehensive study of relevant literature has been undertaken which gives the thesis a depth of information concerning the research problem. Regrettably, study over this lengthy period has also revealed that the difficulties of collaborative working and the weaknesses in social work have persisted over time. Indeed, other investigators have recently described achieving effective collaboration as a 'holy grail' because consistent solutions to the difficulties remain elusive (Salmon and Williams 2001). This finding of enduring problems does, however, give the study a particular significance.

The field research, from pilot to completion, was undertaken between 1994-1996. This took place in one local authority social services area in a rural Welsh county. A survey was conducted with a wide range of health, education and social care professionals: 33 interviews were undertaken and 40 questionnaires completed with doctors, health visitors, psychologists, various therapists and social workers. The research explored practitioners' views on the extent to which collaboration for disabled children was achieved within the locality, and asked health and education professionals what they really thought about the contribution of social workers to the welfare of disabled children and families.

The findings reveal information about how professionals' attitudes towards and expectations of social work are formed. The research also provides insight into professionals' knowledge and conceptualisation about interprofessional working with social workers and considers the actions which they believe necessary to overcome collaborative difficulties.

The interviews with social workers reveal a general lack of confidence in their abilities to undertake child disability work. They blame this largely on inadequate training and insufficient practice opportunities. The research also uncovered social workers' frustrations about not being able to do more for disabled children and families. They experience that the demands of other work, mainly child protection, always take precedence over child disability work. They also consider there to be an inadequate investment of human and financial resources in this field of work. The study found that these matters lead social workers to conclude that child disability work belongs with specialists. Taken together, these findings suggest that the potential for social workers to provide expert services for disabled children is being restricted.

The survey of health and education professionals discovered that others' expectations concerning social work knowledge and skills with disabled children are very low. This was

despite thinking among the same professionals that social workers receive an advanced level of education. However, the study also found these professionals admitting to a general lack of understanding about social work and collaborative working. Some blame themselves for this, while others put it down to inadequate training.

The research also reveals that many professionals claim an empathy with local authority social workers. They perceive that social workers face impediments to effective working from the same sort of problems that affect their work, such as heavy workloads, inadequate staffing and insufficient finance. However, despite this empathy with the difficulties facing social workers, many of these professionals expressed doubts about social workers' abilities in child disability work. These doubts arose from their contact with social workers whose skills in communication and collaboration and whose understanding about the needs of disabled children and families were found wanting.

The findings confirm those of other observers of the field that it is important to address both structural and relational factors at personal and interpersonal, professional and interprofessional, agency and interagency levels to anticipate, prevent and manage difficulties that can adversely affect collaborative initiatives. In Chapter 2, consideration is given to theoretical frameworks that prompt consideration of relevant factors at each of these levels when collaborative initiatives are designed (Challis 1988; Hornby 1993).

The contribution to knowledge that the thesis seeks to make is threefold: first, to theories that try to explain common interprofessional difficulties in collaborative working; second, to debates about the nature and status of social work professionalism; and third, to understanding how social workers in particular could develop strategies to overcome difficulties and to maximise their contribution to the well-being of disabled children and families.

Fulfilling Potential

The study is most concerned with the apparent disparity between the social workers' role with disabled children and families, and the reality of what they are actually seen to achieve for these families. The theoretical explanations that have been suggested for this disparity, which provide reference points in this debate, include Warnock (1978), Barclay (1982), Griffiths (1988) and Payne (1996) who, among others, suggest that it arises because of unrealistic expectations placed upon social workers in view of the scope and volume of their workload. Browne (1982) and Middleton (1996) take a different perspective, arguing that it derives as much from a lack of commitment to disabled children and their families by social workers and their employers, which arises from discriminatory attitudes and a lack of understanding about their needs.

These diverse explanations provide useful insight into the problems affecting social work's ability to fulfil its potential. They also suggest that social work's potential to provide satisfactory services for disabled children may be seriously impeded on a number of fronts; and if action is not taken to grasp the role more effectively and universally it will be further weakened.

The thesis argues that the need for social workers to establish relationships for effective collaborative working must go hand in hand with efforts to ensure that their own services for disabled children are delivered through appropriate service structures. Indeed, it is argued that social work potential can only be fulfilled if mainstream and integrated service structures are established, as advocated by the Welsh Office (1991) and Middleton (1996); and that social work potential will only partly, and therefore inadequately, be realised through the provision of resources solely through specialist or multidisciplinary services. In support of this position comparison is made between multidisciplinary working with disabled children and successful

practice within child protection services, which provides evidence of the social work potential to overcome difficulties in their relationships with other professionals.

While it is recognised that the development of satisfactory social work services for disabled children - the fulfilment of the profession's potential - is dependant upon supporting structures such as training, supervision, adequate and flexible resources, procedures and clear goals and priorities etc., it is nevertheless argued that social workers carry responsibility for their own professional competence in this field of work. This includes learning about other professionals, developing their collaborative skills, improving their knowledge of the needs of disabled children and families, and promoting the importance of integrated service structures within their own organisations.

The Research Study

The following section introduces the organisation of the literature review and discusses how the hypotheses and key research questions are explored in the review and linked to the survey research. The primary aim of the review was to explore existing explanations for the problems affecting social work practice with disabled children. This included particularly the 'relationship difficulties' between social workers and other professionals. The review also aimed to inform the design of data collection tools which could test firstly, whether the difficulties and explanations were similar to those identified in other contexts or localities; and secondly, the researcher's thesis concerning social work potential. This entailed operationalising the issues explored in the review by designing questions in a format that could most effectively gather the information required from a range of professionals.

Chapter 2 explores the importance of interprofessional collaboration and discusses the wide-ranging difficulties affecting this way of working. The chapter identifies how the fulfilment of the social work role with disabled children can be affected by the attitudes and understandings of other professionals, as well as by social work competence in child disability work. A range of theories about how collaboration might be improved are explored. The insights gained from these discussions prompted enquiry with health, education and social work professionals about the factors influencing their collaboration locally. This included asking them about their opportunities for collaborative working; how collaboration takes place; their knowledge about interprofessional working; and the source of this knowledge.

Chapter 3 explores the social work role with disabled children. It identifies the wide-ranging responsibilities that social workers carry under current legislation, and it further highlights why collaboration is essential to the successful fulfilment of these responsibilities. These discussions prompted enquiry with social workers about the social work role in child disability work, and their views about whether other professionals understand this role. The discussions also suggested that asking health and education professionals for their views about the social work role in co-ordinating multidisciplinary care plans might reveal information about social work competence in this field of work. The chapter attempts to isolate that which might be viewed as the distinctive contribution that social workers make to the child's plan; and the survey sought professionals' views about this.

The discussions in this chapter establish that social workers have a primary responsibility to promote respect for their clients' dignity and worth and to advance the social model of disability in their assessment and care planning. This led to enquiry regarding whether other professionals witness social workers promoting these values in their work. The study was

interested to learn whether other professionals saw promoting the principles of integration and equality of opportunity as a particular contribution that social workers make. The study also explored whether social workers viewed this as a key aspect of their role, and if so, how they achieved this within a traditionally medically dominated arena.

Finally the chapter explores the importance of integrated services in maximising opportunities for social integration for disabled children and in minimising the effects of disability. The literature served to highlight how there is no justification for social workers and local authorities treating disabled children any differently to other children. The discussions identify that if child disability work is addressed through mainstream child care services, social workers can develop more effectively their capacity to respond to the needs of disabled children than if the work is undertaken through specialist services. However, the chapter also considers the argument that some level of specialisation may be necessary, at least as an interim measure, to raise standards in child disability social work and to improve social work performance in collaborative working. The discussions in this chapter underline one of the central arguments of this thesis, that the social work potential to make important contributions to the care of disabled children can only be fulfilled if services are provided through integrated structures. Further understanding was sought about these matters during the field research by asking professionals for their views about what characterises an ideal social work service; and by asking social workers for their views about specialisation in child disability work.

Chapter 4 discusses that which characterises and constructs social work as a profession. It explores how far a commitment to 'professionalism' and an improvement in expertise is necessary to fulfil social work's potential in the care of disabled children. It also considers how far others' views of professionalism in social work have impacted on the social worker's role and

contribution in collaborative working. The chapter finds evidence that expertise and commitment are expected of social workers. However, it also finds that, regardless of the competence of individual workers, their success is inescapably linked with the relationship they have with their agencies. Social workers depend upon their agencies to provide the structures, procedures and processes, training opportunities and resources to enable them to practice in the most effective way. These findings suggested that other professionals' views of social work practise might provide useful information about what restricts social work potential; and that social workers' views about their own practice might provide insight into how professionalism and expertise are developed.

Chapter 5 explores the content and quality of social work training. It considers how the training measures up in meeting the requirements of child disability work. The chapter discusses how social work training authorities have responded to concerns about poor practice in some areas of children's services; and it explores why, despite changes to qualifying courses and the increasing availability of post qualifying opportunities, social work training continues to be criticised. These discussions prompted enquiry to social workers about the adequacy of their training and learning opportunities in preparing them for their role in child disability work and interprofessional collaboration. The discussions also prompted enquiry to health and education professionals concerning their observations on whether social workers are adequately qualified for their role. The researcher considered that this line of questioning could reveal whether any lack of credibility for social work training creates difficulties in collaborative working.

Chapter 6 discusses the research aims and methods, and explains the rationale for selecting the questionnaire and semi-structured interview as data collection tools. The researcher concluded that it was neither necessary, nor feasible, to question every area prompted by the

literature review; certain areas of questioning were most likely to provide the required insights and understandings. Furthermore, it was a worthwhile research technique to leave certain issues to one side to see whether respondents raised the matters themselves. For example, social workers were not asked whether they undertook their work from the perspective of the social model of disability; neither were respondents asked for their views on professional commitment and expertise. However, the researcher considered that some open-ended questions, such as asking respondents to describe the 'ideal social worker', might laterally facilitate expression about these and other issues.

Chapters 7 and 8 present an analysis of the research findings, while Chapter 9 completes the dissertation with a conclusion.

Chapter 2

Interprofessional Collaboration

Introduction

The following discussion examines theories that have been proposed for achieving effective collaboration. Generally, these tend to focus on the importance of professionals understanding each others' roles and negotiating the relevance of their particular contributions for children's well being. However, the chapter also explores models of collaborative working that facilitate consideration of other factors that impact on relationships between practitioners from different professions.

The chapter considers the wide-ranging difficulties affecting collaborative working, many of which have been challenging professionals for several decades (Russell 1985; Loxley 1997). Particular attention is paid to insights from Barclay (1982), who identified problems across the UK; and McGrath (1989; 1992) who found many of the same problems seriously affecting child disability services within the locality where this research study was conducted. This exploration is useful in identifying what lays behind particular relationship difficulties between social workers and other professionals.

The chapter identifies difficulties affecting collaboration in five areas of debate. Firstly, there is professionals' lack of understanding about each others' roles and responsibilities, training, knowledge, skills and value base. This affects the relationship by preventing an appreciation and realisation of what others could potentially contribute (Warnock 1978; Craft et al. 1985; McGrath 1992). Secondly, there are arguments regarding the status of the social work profession. Social workers can be seen as failing to make a distinctive contribution based on expert knowledge and skills; and lacking the authority and autonomy that characterise an

accountable profession (Dingwall 1980; Bruce 1980; Wilding 1982; Payne 1996). Thirdly, there are professionals' negative stereotypes of each other, which impede the development of individualised relationships i.e. the development of constructive interprofessional relationships between practitioners where there is respect for each other's roles and responsibilities, and where tasks are negotiated based upon individuals' particular contributions (Kane 1980; George et al. 1986; McGrath 1992; Hornby 1993). Fourthly, there is the assumption of medical leadership within a hierarchical system built upon a medical model of disability. This can prevent the relevance of other professionals' contributions from being recognised (Webb and Hobdell 1980; McGrath 1992; Middleton 1996). And fifthly, there are weaknesses within the structures for service delivery, which can cause care planning to be patchy, disjointed and inadequately resourced (Browne 1982; Welsh Office 1991; Middleton 1996). This chapter seeks insight from these debates to gain a fuller understanding of those matters that aid or impede social workers in fulfilling their potential in collaborative working.

Understanding Collaboration

This section explores what interprofessional collaboration means and entails. The discussions that follow help identify the attitudes, actions and relationships required to achieve effective collaboration.

The term interprofessional collaboration signifies a process wherein professionals learn and work together (CAIPE 1995). It refers also to an orientation to services - characterised by co-operation, partnership and teamwork - and the mechanisms and resources that support this way of working. The purposes of collaboration include meeting the needs of the whole person

and bridging the gap between the different organisation of health and welfare services (Loxley 1997).

Much of current legislation, statutory guidance, public policy and interagency protocol in children's services exhorts practitioners and organisations to work collaboratively. This is particularly the case in child protection, where one enquiry after another has criticised professionals for failing to protect children from abuse, and proposed collaborative actions to rectify the flaws (Home Office 1991; Department of Health 1991). The modern cries for professionals to work together in child protection echo longer standing calls within the disability field, where the fragmentation of health, education and social care services had impeded efforts to progress early initiatives in integrated schooling and community care (Warnock Report 1978; Sines 1988).

Hornby (1993) observes that the difficulties associated with collaboration and the co-ordination of services across agencies have been tackled in many different ways: through joint planning, service restructuring, joint projects, refining procedures and protocols, developing new models for intervention, and through the co-operative efforts of individual workers. However, she finds that despite these measures there continue to be numerous examples of failure in collaboration. These failures reveal that collaborative working is difficult and that professionals require particular skills to perform it effectively.

Loxley (1997) identifies considerable tensions in collaborative working and argues that the term should be removed from political rhetoric and so called 'common sense' where it is too often found, and the case made for it only when it is likely to be effective.

Collaboration should not be a panacea, nor an article of faith, nor dependent on haphazard circumstances, but a taught and resourced part of each profession's repertoire of skills, organisation and culture (Loxley 1997:3).

The UK Centre for the Advancement of Interprofessional Education (CAIPE) argues that a culture in which collaboration can develop is one where professionals give up exclusive claims to knowledge and skills, and recognise that other professionals sometimes have more appropriate skills to meet particular need. It also requires professionals to trust others, to share, communicate and co-ordinate with them, and to develop their understanding of others' knowledge and skills (CAIPE 1995).

An increased realisation of the need for specific skills for collaboration has led to course providers in health, education and social care professions emphasising the importance of learning these skills. The Diploma in Social Work, for example, requires students to display evidence of their ability to 'form effective working relationships with and between individuals, agencies, community resources, volunteers and other professionals'. The Advanced Award in Social Work states that candidates should possess 'highly developed skills in communicating and working effectively and constructively with other professionals in other disciplines across organisational and service boundaries' (The Post Qualifying Consortium For Wales 1993:18).

Models for Effective Collaboration

Models of collaboration are helpful in providing a framework through which all the factors that impact upon collaborative working can be viewed. Developments in the theoretical understanding of collaboration have established new ways of examining relationships between professionals and provided frameworks that are capable of handling many alternative possibilities. For example, by identifying the critical connections between the individual, the group and the organisational structures involved in collaborative initiatives, Hornby (1993) provides a model for developing strategies to overcome problems of collaborative working and

professional communication. She argues that a relational approach to collaborative problems must be paralleled by a structural approach. She highlights the necessity for practitioners and managers to appraise their collaborative skills, and their training and resource needs, for optimal service delivery at each of these three levels: interpersonal (the relationship between individual practitioners), interprofessional (the relationship between different professional groups), and interagency (the relationship between agencies). Hornby suggests that if workers could collaborate better, the help offered would be considerably improved without the need for any extra provision. However, she argues that effective collaboration requires an understanding of the nature of working relationships across professional, agency and other boundaries - this can help in identifying the hindrances to collaboration, and in clarifying what knowledge, abilities and changes in attitude might be needed to enable workers to develop and exercise collaborative skills.

Similarly, Challis (1988) proposed that by separating the key elements of collaboration it is possible to identify where a problem might lie if the outcome is not the one desired. Challis analysed the characteristics of effective collaboration and described it as having three key elements:

- ‘Machinery (structures, procedures etc.)
- + Process of working and learning together
- + Outputs in terms of services to clients
- = Outcomes in terms of benefits to service users.’

Use of Challis’s model demonstrates how effective collaboration will not take place simply because a procedure is established that requires it, or just because a multidisciplinary team structure is adopted. Neither will it come about purely because different professionals think

well of each other and work well together. All three elements must effectively combine to achieve a successful outcome. Challis's use of the term 'machinery' to encompass all structural factors is also helpful in facilitating consideration of how individual agencies organise their internal structures for service delivery, and how these structures can impact upon the entirety of services for disabled children.

Loxley (1997) has also developed a framework of ideas relevant to the theory and practice of collaboration, which draws from knowledge derived from both. She argues that practice is hampered without a theory for collaboration and a coherent framework of ideas within which dialogue can take place concerning the knowledge and skills required for this way of working.

Loxley identifies key concepts that affect interprofessional collaboration in models of health and welfare, in the range of health and social care interventions, and in the organisation and management of resources. She proposes that because collaboration implies an interaction between at least two parties, it is important to consider some general social theory relating to interaction (General Systems Theory, Social Exchange Theory and Co-operation Theory). Because collaboration takes place within a practice context, it is also important to consider those philosophies and ideologies about health and welfare that underlie particular service models and determine modes of intervention, the range of skills, and the form of organisation. Furthermore, because collaboration takes place within a social context it is important to consider the ideologies that shape social organisations.

The concepts Loxley derives from social theory are particularly useful in identifying where consensus might be achieved among participants about competence in collaborative work. Three categories of concepts are identified as relevant. The first category, attitude, draws from

the concept of 'commitment'. For effective collaboration, it is important that all parties perceive a need for this way of working, and that they commit to developing trust and predictability for other participants. The second category, knowledge, requires participants to understand the boundaries, structures and processes that characterise social systems. This is necessary for them to know what they are dealing with when working together, so that they are not overcome by the difficulties. The third category, skills, requires participants to identify the essential elements of the social network and to manage interactions between these elements. This involves establishing appropriate structures and resources, clarifying roles and responsibilities, and defining tasks in terms that all participants can agree.

Loxley's framework identifies that effective collaboration depends on professionals and agencies sharing a perception of what is required and what is to be gained from collaboration. Most important is that they share a 'recognition of interdependence' and a perception of 'long-term credit creation' that benefits not only individual clients, but professionals, their agencies and the effective use of resources (Loxley 1997: 41).

The models discussed have particular usefulness for application in this research concerning practitioners' experiences of collaboration, as they allow a focus to be placed upon local, specific, inter-relational aspects without losing sight of the wider context.

With collaboration defined and frameworks identified through which to view it, the following discussions explore some of the problems that affect this way of working, particularly for social workers.

Multidisciplinary Working: a solution to collaborative difficulties

Many difficulties in collaborative working appear to be long-standing and intractable. In his examination of interagency co-operation in the organisation of learning disability services, Russell (1985) argues that while 'today's services have been built upon the heritage of the past... the rivalries of past generations continue to impede working relationships.' Russell observed this particularly in the 'jealousy between those working in the National Health Service and in the local authorities about the allocation of resources [which] ensures that the divisions of the past are perpetuated in the present.' Similarly, Loxley (1997) has argued that tensions between health and social care agencies and professionals, which have existed since the 1940s, persist today within the broader context of collaborative working, in the organisation, finance, management and goals of health and social services. Both writers consider that these long-standing difficulties reflect divisions at interpersonal, interprofessional and interagency levels.

Russell maintains that tackling these divisions depends upon creative ideas for new patterns of services and a willingness from professionals to accept new structures. He emphasises the value of collaboration for client and patient care, and he highlights where radical and innovative thinking during the 1980's led to partnership documents being drawn up between health authorities and social services departments that agreed to resources being pooled. These initiatives commonly emphasised the value of multidisciplinary teams in co-ordinating services and overcoming difficulties in collaboration (see for example Healy 1991). Indeed, throughout the 1980's initiatives in interprofessional collaboration tended to be seen in terms of multidisciplinary teamwork.

The apparent success of some multidisciplinary initiatives led to a rapid growth in this way of working, particularly in disability services. This growth gained support from the view

that increased contact between professionals would improve their appreciation of what each had to offer, which would lead to better joint working and ultimately a better service. This view was founded on the conviction that arrangements for professionals to work directly together would enable them to overcome previously recognised difficulties. Indeed, some research has shown that many practitioners consider that the barriers between different professional groups and agencies are so great that only by working in the same setting within a formal multidisciplinary team can they be sufficiently overcome (McGrath 1992).

Some writers have compared the urging of professionals in the disability field to work closely together and to establish teamwork practices to a 'social movement'. However, Lonsdale et al. (1980) consider that the significance of the wider context of collaborative working was not sufficiently recognised. They argue that the haste and enthusiasm for teamwork, and the consequent reorganisations, simply added a new set of problems without doing much to resolve the old ones.

Social Work Difficulties in Collaboration

Barclay's (1982) examination of social work practice within local authority social service departments provided insight into some of the problems, old and new, which at the time appeared to be most significant in influencing attitudes towards social workers and constraining effective collaboration. The problems he identified included: the lack of a tradition of collaborative efforts between social workers and others; differences in autonomy, accountability, seniority and status; and different opinions about the nature of clients' problems.

Barclay's findings are valuable in this debate about social work potential because they highlight the significance of professional status in collaborative working. Barclay found that

differences in status, and ways of working that are generally associated with professionalism, often caused interactions between practitioners to be characterised by mutual wariness, consciousness of differences in prestige, and defence of territory. He identified that particular tensions arose between professionals if they were not 'alive to the need both to explain to each other the premises on which their work is based and the constraints upon them and to understand what each other is and is not able to do' (Barclay 1982:115). Barclay considered it particularly important that social workers should give others these explanations, because most people 'only had a vague idea of what to expect of social workers.'

Barclay identified another feature of social work that is significant in this debate. He found that social workers 'operate uneasily on the frontier between what appears to be almost limitless needs on the one hand and an inadequate pool of resources to satisfy those needs on the other' (1982: vii). He thought that parliament 'imposed' too many demands upon social workers, and that they struggled to cope with the 'complex pressures' that they faced. He observed that 'Too much is generally expected of social workers. We load upon them unrealistic expectations and then we complain when they do not live up to them' (1982: vii). Barclay argued that these pressures had a very negative impact on social workers' relationships with other professionals. He found evidence where these pressures had caused reciprocity, mutual trust and a sense of partnership between social workers and other professionals to be 'scanty or absent' (1982:115)

While arguing that 'mutual respect' should provide the foundation for effective collaboration, Barclay asserted that 'goodwill is not enough to guarantee adequate collaboration' (1982:125). He concluded that effective collaboration requires very careful planning and, like Hornby (1993), he proposed that many difficulties could be addressed if all concerned 'develop

awareness and understanding of the factors that influence interactions between them...' (Barclay 1982:116).

Barclay also asked parents of disabled children about the social work services they received. On the whole he found parents dissatisfied. His findings are helpful in highlighting certain practice issues that can impact on how social workers are viewed by others.

Parents said that they wanted support and help in coming to terms with their child's disability and in coping with emotional stresses and tensions. However, many of them reported having had little or no contact with social workers. Families who had received occasional social work contact complained that 'no help was given when it was most needed during the first few years of the child's life' (Barclay 1982:167). Parents also complained that social workers lacked knowledge about specific disabilities, about services, welfare benefits and the voluntary organisations that could offer help. While parents thought that one of the main social work tasks was to help them find resources to solve their problems, Barclay found that many families were unaware of the services available from social service departments. Many parents also found that social workers were unable to cope with their needs - and so they tried to pass them on to others. Furthermore, parents thought that social workers were incapable of reaching decisions without consulting others.

Despite these rather negative findings, it is significant for this thesis that Barclay also found 'evidence of competent, imaginative and innovative practice' and 'heartening evidence...of effective, sensitive, and well-planned collaboration' (1982:55; 115). This evidence shows that social workers are capable of overcoming the practice weaknesses and collaborative difficulties described above. The following discussion considers how they might go about achieving this.

More Than Mutual Respect

In the first edition of 'Mental Handicap - a multidisciplinary approach', Craft, et al. (1985) encouraged collaborative working. Their ideas attempted to address some of the difficulties mentioned above. They proposed the use of a 'matrix of care' into which the various skills of professionals could be directed to achieve services underpinned by the philosophical goal of normalisation (1985:4). Collaboration was proclaimed as the process by which this goal would be achieved. Craft et al. argued that effective collaboration requires good teamwork and 'commitment and loyalty' from each member (1985:4). It also entails professionals acknowledging that the needs of their clients are many and varied, and can only be met effectively by a 'team of helpers' (1985:4)

However, these writers identified that issues of professional status and territoriality particularly complicated collaboration within multidisciplinary teams. These difficulties had been identified in other settings in relation to the assumed authority of medical practitioners over the allied professions, including social work. However, Craft et al also demonstrate how work in the field of disability has developed increasingly around the overall contribution of the multidisciplinary team. This has particular significance for the discussion of social work in this thesis, because it reflects how the development of different professional contributions brought about a challenge to doctors and to the medical framework through which individual's needs had traditionally been assessed. These matters are further considered below and in Chapter 4.

Craft et al. considered that mutual respect and a 'sympathetic understanding' of others' roles would enable workers to overcome collaborative difficulties and to gain due recognition for their contributions (1985:4). However, as Barclay (1982) argued, this emphasis on mutual

respect between individuals is not enough, there is also a need for practitioners and managers to develop specific skills for collaborative working.

Webb and Hobdell (1980) have challenged the view that mutual respect is sufficient to overcome collaborative difficulties. They developed a model for multidisciplinary care planning based on the principle of 'the authority of relevance' (1980:106). They argued that the right to contribute to decision-making must arise from 'the possession of knowledge of relevance to the client's own feelings of well being' rather than from the 'authority of position' (hierarchy), or from professionals' claims to 'authority of knowledge' (1980:107).

Both Webb and Hobdell's model and Craft et al.'s matrix of care suggest that social workers could command significant authority of relevance - within and outside multidisciplinary team structures - if their contribution is based on a holistic assessment of the needs of disabled children and families, particularly if this includes consultation with children themselves. Achieving this authority would, however, require social workers to use collaborative skills in presenting their contribution and, if necessary, explaining the value of it in multidisciplinary meetings - where other professionals hold established positions of authority and are confident in the relevance of their knowledge.

McGrath (1992) considered the issues of relevant knowledge and skills during her research into 'Community Mental Handicap Teams' in Wales. She also observed the persistence of factors that acted as constraints on collaborative working, including arguments concerning status; a tendency by the medical profession to assume dominance and to be reluctant to devolve tasks; an inclination by professionals to stereotype each other; and their ignorance about each others' work. McGrath's research showed the importance of professionals having the skills to explain and negotiate their roles according to the relevance of their knowledge and skills to

individual clients. And she found evidence of social workers using these skills: 'the traditional supremacy of doctors is being challenged, as the newer professions such as social work and nursing gain confidence and as their professional roles develop'(1992:48). This finding suggests that social workers can overcome certain collaborative difficulties if they are confident in fulfilling and articulating their role, and if they can convince others of the value of their contribution.

The Need to Negotiate Status Relationships

However, the lack of progress in these matters has led to others doubting social work competence. For example, Dingwall (1980) identified that the traditionally poor relationships between social workers, health visitors and general practitioners, across a range of settings, arose from others' uncertainty about social work competence. However, other factors complicate this: Dingwall found that other professionals resisted the development of the social work role because they viewed it as a threat to their practice territory. Dingwall's solution to this conflict and 'territoriality' was similar to Webb and Hobdell's. He argued that social workers need to resolve uncertainties surrounding the definition of their own 'task domain', and they need to learn how to negotiate status relationships with others. This is particularly important in the arena of childhood disability where the overlap in professionals' contributions can raise debate about whether social work has anything discrete or special to offer.

McGrath (1992) also observed problems for social workers in this vein, and she proposed a similar solution. She noted that health workers in multidisciplinary teams usually come from different professional disciplines each with relatively distinct roles and specific knowledge and skills, which identify them as 'professionals' and specialists. Yet in contrast, others may view all

social service staff as semi-professional. McGrath considered that this perception of their semi-professional status, alongside the widespread appointment of unqualified workers by local authorities, presented a barrier to social workers' relationships with other professionals.

Exploring this further, McGrath gathered social workers' views about collaboration with professionals working outside their multidisciplinary teams. While social workers reported few apparent problems arising from status issues when working with other professionals in the same team, they often experienced substantial difficulties in liaison with professionals outside the team. This was particularly the case with doctors. McGrath's findings led her to conclude that one of the major challenges of interprofessional working was that of establishing credibility and identity with others (McGrath 1992).

McGrath's understanding of the problems has particular relevance in this thesis because, in 1990, she was commissioned to undertake a study with a view to recommending a solution to the collaborative difficulties arising within children's services in West Wales. During her study of community mental handicap teams, McGrath reported that the obstacles in the way of interprofessional working for children with intellectual impairments gave cause for major concern. She found there to be 'striking' difficulties evident in professional, organisational and administration liaison in the co-ordination of children's services (1989:137). The following discussion considers her proposals for how social workers could overcome these difficulties.

Overcoming Collaborative Difficulties in Child Disability Services

McGrath recommended that effective collaboration could be achieved by employing specialist social workers within multidisciplinary teams to work alongside health visitors, community nurses and specialist teachers. Together these professionals could provide a

keyworker system for children and families. This structure mirrored the make-up of the adult learning disability teams and was the arrangement in operation at the time of this research.

Thus the solution to collaborative difficulties in children's services entailed linking professionals together in specialist teams. The development of these teams was intended to complement existing services. Keyworkers would act as additional helpers for those children with the most severe intellectual impairments, assisting them and their families in accessing both specialist and mainstream services. McGrath considered that the role of keyworker in co-ordinating multi-professional input to a child's plan did not exclusively belong to social workers. She argued that other health and welfare workers, with different qualifications, could undertake this role. On the one hand this model of service organisation gave social work a specialist position and established the profession on an equal footing with others in the teams. On the other hand it blurred the already frail distinction of roles by bucking against the White Paper (DoH 1971) assertion that social workers were best qualified to undertake the co-ordinating role. This point is significant because it highlights the importance of social workers being able to define their tasks and negotiate their role in collaborative working when 'traditional' roles and responsibilities become blurred.

However, such negotiations are not easy. McGrath's finding that even specialist workers face difficulties collaborating with professionals outside their team structures has significance for all social workers. If specialist social workers find it hard to establish credibility, despite their opportunities to develop relationships and collaborative skills through multidisciplinary teamwork, then other social workers in mainstream child care services, who have much less frequent contact with other professionals about disabled children, are likely to find it harder still.

An opportunity to address these matters arose when the government issued its Children Act Guidance on working with disabled children (DoH 1991). This directed that the needs of disabled children and families should be met through mainstream services. Thus specialist services needed to utilise and support, but not replace, services available to all children. For this to be achieved, all child care professionals would need to develop knowledge of the needs of disabled children and skills in collaborative working. While the Guidance stressed the need for collaboration at all stages of assessment and service provision, at field level and in management planning, the authors argued that the success or failure of collaboration ultimately rested upon the personal relationships formed between professionals: 'Family support will require effective co-ordination, communication and mutual respect between and with professionals and services in the community' (1991:7.1). The Guidance did not, however, discuss the substantial difficulties that, as this chapter has shown, usually arise in interprofessional and interagency working.

The Bigger Picture

Dale (1996) argued that while the authors of the Children Act Guidance acknowledged that families' needs for diverse services required social workers to negotiate with budget holders and service managers across agencies, they did not address the impact of competing demands on these stakeholders. Such demands create collaborative difficulties for social workers and affect the efficiency with which they can meet the needs of disabled children and families. Dale argues that while the authors of the Guidance stressed that the key to effective collaboration and improved care management lay in positive interpersonal relationships between professionals, they gave insufficient attention to the importance of agencies' supporting structures (Dale 1996).

The Joseph Rowntree Foundation (1995) expressed similar concerns about the government's approach to collaboration. They argued that health and social care agencies failed to recognise the crucial importance of supporting structures in enabling practitioners to focus on their particular contributions. The Foundation's research into practice across the UK, found that a lack of structured interagency co-ordination and resource commitment was limiting the effectiveness of interprofessional interventions for children with special needs.

Practitioners continue to feel threatened by, and anxious about, inter-agency collaboration. Where conflicts arise these are often attributed to personalities and individual agency difficulties rather than to the lack of structure which would support and validate collaboration (Joseph Rowntree Foundation 1995:1).

The research revealed that failed attempts by agencies to work together had left practitioners frustrated with the process. In some localities a whole agency was found to be the scapegoat for the failure of an interprofessional initiative. In such situations, the Foundation found that, 'The hostility and suspicion that develops further hinders successful co-operation; workers retreat to their own 'patches' where they feel safer and more able' (Joseph Rowntree Foundation 1995:2).

The Foundation argued that despite the expectations of government that professionals and agencies should work closely together they still spent too much time working on their own and too little time in co-operation and joint planning. Furthermore, each agency struggled to define and explain their roles, aims and priorities and how these related to those of other agencies. The Foundation argued that these matters created difficulties for practitioners in dealing with the child 'as a whole' and in offering families a 'seamless service.'

These findings constitute a sad commentary on the state of collaboration for disabled children. They highlight how interprofessional collaboration can sometimes be complicated, demanding and frustrating. However, disabled children and families require professionals who

are able to deal with the complexities of collaboration - this is, after all, one reason why the co-ordinator role was created. The findings of the Joseph Rowntree Foundation also highlight how social workers require particular skills in collaboration if they are to fulfil their potential. These include skills in negotiating their role and defining their work in terms that others understand.

The findings also show that the problems of collaboration may cause social workers to avoid this way of working. These findings display weaknesses in social work's potential to play a leading role in collaborative care for disabled children; without collaboration social workers cannot arrange holistic assessments and seamless services.

The Foundation identified a range of features that have been found to be critical to the success of collaborative initiatives in child disability services. The following features reflect the value of using a theoretical model, such as those described at the beginning of this chapter, for pre-empting, and taking action to minimise, the likely difficulties that can affect collaborative initiatives:

- a) formal commitment and support at all levels (political, management and practitioner);
- b) regular interagency meetings to share information and develop strategies in the light of changes in legislation and practice, or due to the identification of gaps in provision;
- c) agreed definitions and common work practices;
- d) agreement about the scope of the client group;
- e) agreement about ownership of problems so that early intervention can be achieved;
- f) mechanisms for exchanging information as and when necessary;
- g) a framework for data collection and statistical analysis which can inform practice across agencies;
- h) systems for monitoring and evaluating the work;

i) joint training in order that professionals understand each other's roles.

The thesis argued is that for social workers to address practice weaknesses it is important that agencies view collaborative work within a framework through which the features listed above can be considered. Such analysis would also reveal the structures and resources that social workers need to fulfil their potential and to overcome collaborative difficulties.

Conclusion

The discussions in this chapter have highlighted the considerable difficulties associated with collaborative working. The evidence of the writers cited shows that effective collaboration requires social workers to develop a repertoire of collaborative skills, and a willingness to create and accept new ways of working. The discussions show that social workers cannot achieve effective collaboration without the support of their employers. The finding that social workers struggle to cope with apparently 'unrealistic expectations' highlights the particular importance of local authorities ensuring that their workers are supported through appropriate structures and sufficient resources (Barclay 1982).

Loxley's (1997) work shows that interprofessional collaboration is such a demanding task for all concerned that it makes good sense only to adopt this way of working when really necessary. The view of the writers referred to in this chapter is that collaboration is essential for social workers aiming to meet the needs of their clients holistically. The next chapter explores the social work role, and gives further consideration to why collaboration is fundamental to their contribution.

This chapter has also highlighted the value in using a theoretical model of collaboration as a framework for analysing interpersonal, interprofessional and interagency matters relevant to

child disability services. The frameworks discussed show that while addressing issues on any one of these three levels can lead to improvements, if the benefits of collaboration are to be maximised for disabled children and families, and if social work potential is to be realised, it is important to address issues at each level. Further reference is made to this matter in Chapter 9. The following tables provide a summary of the difficulties in collaborative working and the possible solutions that have been discussed in this chapter.

Table 1

Interpersonal Relationships in Collaboration

DIFFICULTIES	SOLUTIONS
Differences in perspective and opinion about the child's and family's needs (<i>Webb & Hobdell 1980; McGrath 1992</i>)	Acknowledge the many and varied needs of clients and hence the importance of teamwork (<i>Craft et al 1985, McGrath 1992</i>)
Ignorance about each others' roles and contributions - impeding referrals and co-ordination (<i>Barclay 1982; McGrath 1992</i>)	Improve understanding of interprofessional collaboration. Improve knowledge and appreciation of others' roles. Increase direct contact with other workers (<i>Barclay 1982; Craft et al 1985; Children Act 1989; Healy 1991; McGrath 1992; Hornby 1993</i>)
Conflict arising from territoriality over roles and responsibilities (<i>Barclay 1982; Russell 1985</i>)	Develop skills in negotiating roles and tasks (<i>Dingwall 1980; Craft et al 1985</i>)
Workers' tendency to negatively stereotype each other, which impedes the development of individualised relationships (<i>Kane 1975; George et al. 1986; McGrath 1992; Hornby 1993</i>)	Realise and assert distinct contributions and develop the confidence to challenge stereotypical views (<i>McGrath 1992</i>)
Wariness, mistrust, hostility, lack of goodwill - impeding partnership and reciprocity (<i>Barclay 1982; Russell 1985; Hornby 1993</i>)	Improve knowledge of other workers' roles. Respect individual's contributions. Develop commitment and loyalty to teamwork (<i>Barclay 1982; Craft et al 1985</i>)
Health and education professionals' lack of confidence in social work competence (<i>Dingwall 1980; McGrath 1992</i>)	Social workers to convince other workers of their competence by increasing their knowledge (through training) and developing their skills in establishing identity and credibility (in multidisciplinary arenas) (<i>Dingwall 1980; Craft et al 1995; Hornby 1993</i>)

Table 2

Interprofessional Relationships in Collaboration

DIFFICULTIES	SOLUTIONS
Lack of tradition in collaborative working. Tradition of particularly poor relations between GPs, social workers and health visitors (<i>Dingwall 1980; Barclay 1982; Russell 1985; Loxley 1997</i>)	Improve understanding about the nature of working relationships across professional boundaries. Organise joint training and promote the appreciation of other workers' contributions (<i>Warnock 1978; Lonsdale et al 1980; Barclay 1982; Challis 1988; Hornby 1993; Joseph Rowntree Foundation 1994</i>)
Differences in perspective and opinion about the child's and family's needs (<i>Webb & Hobdell 1980; McGrath 1992</i>)	Acknowledge the many and varied needs of clients and hence the importance of teamwork. Make values and principles explicit (<i>Craft et al 1985, McGrath 1992</i>)
Conflict arising from territoriality concerning roles and responsibilities (<i>Barclay 1982; Russell 1985</i>)	Provide training for workers to develop skills in negotiating roles and tasks with other professions (<i>Dingwall 1980; Craft et al 1985</i>)
Lack of confidence in social work competence (<i>Dingwall 1980; McGrath 1992</i>)	Convince other workers of competence. Develop skills in establishing identity and credibility (<i>Dingwall 1980; Craft et al 1995; Hornby 1993</i>)
Differences in autonomy and accountability in decision-making, differences in authority, seniority and status. Consciousness of differences in prestige and position (<i>Bruce 1980; Barclay 1982; McGrath 1992; Payne 1996</i>)	Develop skills in negotiating roles and tasks, and in establishing identity and credibility. Recognise the 'authority of relevance' to decision-making. Develop distinct roles and encourage equality and collaboration among professionals (<i>Dingwall 1980; Craft et al 1985; McGrath 1992; Hornby 1993</i>)
Tendency for medical professionals to assume dominance and to be reluctant to devolve tasks (<i>McGrath 1992</i>)	As above, and also: develop confidence to challenge medical dominance - confidence in the social work contribution and in articulating the 'social model of disability' (<i>McGrath 1992; Middleton 1996; Dale 1996</i>)
Lack of specialisation and distinct contributions that identify social work as 'professional' in the eyes of other workers (<i>McGrath 1992</i>)	As above.
Low priority and status given to work with disabled children and families (reflected in the appointment of unqualified social workers) (<i>Browne 1982; McGrath 1992; Middleton 1996</i>)	Recognise the importance of providing a quality, co-ordinated and holistic service for disabled children through mainstream integrated service structures. (<i>Browne 1982; Welsh Office 1991; Middleton 1996</i>)
Inadequate training about the roles of other professionals and concerning collaborative working (<i>Barclay 1998; Griffiths 1998; McGrath 1992</i>)	Organise training at basic, qualifying and post qualifying levels (<i>Warnock 1978; Griffiths 1998; Children Act 1989; JR Foundation 1994</i>)

Table 3

Interagency Relationships in Collaboration

DIFFICULTIES	SOLUTIONS
Lack of understanding about the nature of working relationships across professional, agency and other boundaries, which impedes agency management from identifying the hindrances to collaboration. Rivalries, jealousies and tensions arising from the past concerning resource allocation, organisation, management and goals which continue to impede collaboration (<i>Lonsdale et al 1980; Barclay 1982; Russell 1985; Challis 1988; Hornby 1993; Loxley 1997</i>)	Develop theoretical and practical understanding about collaborative working. Clarify the knowledge, abilities and changes in attitude required to develop and exercise collaborative skills. Overcome rivalry and jealousy through creativity by designing new structures and service patterns based on pooled resources (<i>Barclay 1982; Craft et al 1985, Challis 1988; McGrath 1992; Hornby 1993</i>)
Failures in collaborative initiatives, including geographical boundary disputes, and lack of resource commitment, which leads to frustration among practitioners (<i>Griffiths 1998; BASW 1992b; Joseph Rowntree Foundation 1995</i>)	Ensure that agency structures and multi-agency agreements can support interprofessional working. Ensure sufficient resources for social workers to undertake assessment and care planning tasks with competence (<i>BASW 1992b; Joseph Rowntree Foundation 1995; Middleton 1997; Challis 1998</i>)
Agencies facing competing demands for resources. Lack of leadership and direction, and a lack of clarity about service goals within local authorities (<i>Griffiths 1998; Dale 1996</i>)	Establish an interagency strategic approach with clear goals and agreed work practices and protocols. Identify leaders (<i>Craft et al 1985; Healy 1991; Joseph Rowntree Foundation 1995; Hornby 1993; Loxley 1997</i>)
Insufficient training (<i>Warnock 1978; Barclay 1982; Griffiths 1998; Joseph Rowntree Foundation 1995</i>)	Arrange joint training for managers and practitioners, and encourage individuals' professional development (<i>Warnock 1982; Children Act 1989; Griffiths 1998</i>)
Lack of referrals to social workers and SSDs from other professionals (<i>Threlfall 1979; BASW 1992a; 1992b; 1992c</i>)	Introduce procedure for referrals to be made routinely to SSDs for all disabled children (<i>Threlfall 1979; BASW 1992a; 1992c</i>)

Table 4

Social Work Responsibilities in Collaboration

DIFFICULTIES	SOLUTIONS
<p>Failure to:</p> <ul style="list-style-type: none"> • support disabled children and families • undertake important roles (including the key worker role) • make important contributions • tackle oppressive practice and discriminatory service structures • ensure and promote accessibility and inclusiveness for disabled children and families in local authority facilities and services • establish preventative services <p><i>(Bayley 1973; Browne 1982; Audit Commission 1994; Middleton 1996)</i></p>	<p>Social workers' professional responsibility for developing specific knowledge and skills (without resorting to narrow specialisation).</p> <p>Social work realisation of the importance of their roles and responsibilities, including challenging oppressive and discriminatory practices and to promote and advocate for inclusiveness and accessibility for disabled children to mainstream facilities.</p> <p><i>(Bayley 1973; Browne 1982; Middleton 1996)</i></p>
<p>Low priority and status given to work with disabled children and families (including allocation to unqualified workers)</p> <p><i>(Browne 1982; McGrath 1992; Middleton 1996)</i></p>	<p>Social work acknowledgement of the importance of skilled holistic assessment and care management for disabled children, and of the higher risks of child abuse. Social workers' professional responsibility to advocate on behalf of disabled children and to demand adequate resources to meet their needs</p> <p><i>(Browne 1982; Middleton 1996)</i></p>
<p>Persistence of discriminatory attitudes among social workers</p> <p><i>(Browne 1982; Middleton 1996)</i></p>	<p>Social work acknowledgement of the inconsistencies in their approach to disabled children, and the need to address as above.</p> <p><i>(Browne 1982; Middleton 1996)</i></p>
<p>Narrow specialisation and restrictive definitions of 'children in need', which create barriers to access and can reinforce social exclusion for disabled children and families. Difficulties in collaboration between social workers, and failure to transfer knowledge across specialist areas</p> <p><i>(Welsh Office 1991; Middleton 1996)</i></p>	<p>Social work resistance of narrow specialisation. Social work creation of efficient mechanisms for exchanging knowledge with colleagues</p> <p><i>(Welsh Office 1991; Middleton 1996)</i></p>
<p>Family's experience of social work help as stigmatising. Lack of information for families about the social work role</p> <p><i>(Gilbert 1985; JR Foundation 1994)</i></p>	<p>Clearly define and publicise the social work role and contribution to services</p> <p><i>(Gilbert 1985; JR Foundation 1994)</i></p>

<p>Inadequate expertise in dealing with the sorts of problems faced by disabled children and their families <i>(Threlfall 1979)</i></p>	<p>Improve generic training and opportunities for specialist training. Integrate services for disabled children with mainstream children's services <i>(Threlfall 1979; Welsh Office 1991; Browne 1982; Middleton 1996)</i></p>
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Chapter 3

Social Work Roles and Responsibilities

This chapter first explores the evolution of social work roles and responsibilities with disabled children and families, and the value of the social model of disability as a framework for guiding social work practice. The chapter then considers the organisational structures that might best assist social workers in fulfilling their roles and responsibilities and in achieving effective collaboration.

Understanding about the social work role is sought from government instigated reports and legislation (DHSS 1971; Warnock 1978; Jay Committee 1979; Barclay 1982; Griffiths 1988, The Children Act 1989; The Community Care Act 1991; NAFW 2001) and from research (Bayley 1973; Threlfall 1979; Audit Commission 1994). The exploration reveals the importance of the social work role in supporting families and promoting the welfare of disabled children, particularly through conducting holistic assessments and co-ordinating multidisciplinary care plans. The chapter considers the argument that social work has a distinct contribution to make arising from skills, training and values that are particular to the profession (Barclay 1982; BASW 1991a). It also explores the argument that despite the importance of their roles, and despite the claims made for their skills, social workers too often fail to make the contributions expected (Bayley 1973, Browne 1982, Audit Commission 1994; Middleton 1996).

In discussing the social model of disability, the chapter finds that different perspectives on disability can affect professionals' attitudes and behaviours towards disabled children and impact on the way that agencies provide services (Middleton 1996; Morris 1997; Loxely 1997). The discussion considers whether discriminatory attitudes among social workers, or their lack of

an understanding about the value in using the social model as a practice framework, restrict the fulfilment of their role and potential in collaborative working (Browne 1982; Middleton 1996).

The discussion of organisational structures demonstrates the need for local authorities to establish service arrangements that are responsive to families (and other professionals) and which ensure that disabled children can access mainstream services and opportunities for social integration (Browne 1982; Welsh Office 1991). The importance of this is revealed through a discussion of the problems that can arise if different elements of the knowledge required for meeting the needs of disabled children are split across various service areas (Welsh Office 1991: Middleton 1996).

Social Workers 'Best Placed' to Co-ordinate

Current legislation calls for close co-operation between professionals in assessing the needs of disabled children, and it reiterates previous proposals for the social worker to act as a co-ordinator of the various professionals' inputs (DoH 1991a; NAFW 2001). The social work role in co-ordinating interprofessional care plans was first put forward in the late 1960's when the increasing complexity of the welfare system, alongside the enormous growth in knowledge in social and medical sciences, was leading to further and further specialisation within and across occupational groups. It had become clear that no one profession could know and do everything required for disabled children. Health and education professionals usually held specific task-oriented roles, yet they often had concerns about the general welfare of their clients, such as: the stresses of caring; the effect of the child's special needs upon other family members; the impact of the disability and professional interventions upon the child, the financial implications of caring, and the co-ordination of services. Yet these professionals often had neither the time nor

the skills to manage these issues. Consequently they needed to defer to someone who did - someone with a specific role and yet a broader remit, who could take an holistic approach drawing from knowledge across all the professions. In 1971, the Department of Health and Social Security stated in the White Paper 'Better Services for the Mentally Handicapped' that the social worker was such a person:

Many people... have a contribution to make in advising parents... The person best placed to act as a co-ordinator is likely to be the Social Worker, who should take her part in the multi-disciplinary team as soon as handicap is suspected and thereafter maintain a continuing relationship with the handicapped child and his family. (DoH 1971)

The importance of support for parents was reinforced at the time by research, which found that a caring and stimulating home environment held significant advantages for the development of disabled children over institutional settings, such as hospitals, residential homes and special schools (Bayley 1973). There was firm evidence that important benefits could be derived for disabled children from normal and integrated childhood and family experiences. Professional support for parents was considered essential to the realisation of these benefits (Bayley 1973; Collins and Collins 1976; Jay Committee 1979).

Bayley's (1973) research identified the value of support services, counselling and advice for the child, their parents and other family members if the greatest benefit was to be derived from 'normalising' the child's life so that they could reach their fullest developmental potential. Bayley found that families greatly valued those social workers who provided these services. She also argued that such services proved most effective when co-ordinated with the work of other involved professionals.

Thus, during the 1970's, the social work role developing to encompass a range of skills and responsibilities, including:

- a) Offering advice and support, particularly to those who were vulnerable or under stress;
- b) Acting as advocate, facilitator or advisor over such matters as financial grants and benefits or gaining access to support services;
- c) Intervening, using a range of social work knowledge and skills, and perhaps statutory measures, in dealing with serious individual or family problems;
- d) Providing information for others regarding the family. For example, through a social history or home assessment, while also being able to advise others about the child and family's holistic needs.
- e) Co-ordinating the contributions of other professionals involved.

The fulfilment of this role required wide-ranging knowledge and skills in disability work as well as confidence in collaboration. The efficient performance of the role also depended on the willingness of other professionals to work with social workers, and to make use of the breadth of the social worker's contribution.

However, the literature of the time reports that these matters were complicated by a lack of clarity about what others could expect from social workers, which affected their ability to make best use of social work skills. This lack of clarity was perceived to arise because social workers had neither the expertise nor a sufficient statutory framework upon which to base their services (Threlfall 1979; Barclay 1982; Gilbert 1985; Heddell 1988).

Role Confusion

Threlfall's (1979) research provides insight into the complications caused by the lack of clarity about the social work role. She conducted interviews with social workers and a range of other practitioners for the influential Warnock Committee. Threlfall's focus was placed on the difficulties social workers faced in providing counselling for parents of disabled children. She observed a discrepancy between what social workers felt their role *should be* in helping families and what they actually felt able to offer. Some social workers considered they should play the major part in counselling, rather than health visitors (and those social workers who expressed an opposing view were found to be apologetic about it). Threlfall identified several reasons why social workers were not in fact able to fulfil their role as counsellors: firstly, there was no automatic referral of children to their department, so they often only knew about the child if the family presented with additional problems or applied for specific services such as aids and adaptations; secondly, there was a serious shortage of adequately trained social workers and a lack of expertise in dealing with the sorts of problems faced by disabled children and families.

Threlfall argued that the lack of expertise arose because social workers had not traditionally been involved in this field, and that the generic nature of social work training did not usually provide social workers with the necessary specialisation. Study of the history of services for disabled children, however, shows that there had been significant social work involvement with disabled children over many decades (COS 1893; Penrose-Trevelyan 1923; Woodroffe 1962; Pritchard 1963). It is likely therefore, that Threlfall's reference to a lack of involvement refers to tradition in more recent decades. Arguably, today's social work role is founded on an earlier heritage of social work involvement, combined with the continuing claims of social work

to have the knowledge and skills appropriate for interprofessional collaboration and child disability work. However, Threlfall's findings suggest that, despite this heritage and these claims, training and practices in this area of social work have not kept pace, and perhaps have been neglected, as the work has become increasingly specialised.

Threlfall also found the confusion about what social workers were and were not able to do further complicated by competing financial and political demands upon local authorities' resources. This caused social work to concentrate on delinquency and child protection work. In the light of these demands, Threlfall enquired to managers about the lack of social work services for disabled children. She found that managers recognised the needs of disabled children and families for 'continuous counselling,' and they considered that 'ideally the social worker should take on the major role of counselling' (1979:19). Nevertheless, they argued that they were often unaware of disabled children living locally. In any event they thought the GP or health visitor could provide the necessary service in the absence of 'a mature, qualified social worker' (1979:19). This point is significant because it suggests that managers did not consider the argument that social workers 'ideally' fulfil this role because they can help clients in distinctive ways that other practitioners do not.

In her interviews with practitioners, Threlfall also found that social workers perceived reluctance from health professionals to view the care of disabled children as a shared responsibility. Social workers thought that health visitors were 'putting families off' from seeking their services (1979:19). Indeed, Threlfall did find that health workers' doubts about social work competence, and some stereotypical opinions, affected their willingness to refer families to social services. They perceived social workers as 'untrained', 'too young and

inexperienced', and too slow at responding to referrals (1979:19). These views also caused difficulties in collaborative working more generally:

Relationships between Social Services and Health Departments varied from being uncertain, with a willingness to co-operate and to define their respective roles with regard to young handicapped children, to being strained or even hostile, at least on the part of individual workers (Threlfall 1979:19).

Hence Threlfall's findings provide further insight into the multi-faceted nature of collaboration, where problems can arise from the attitudes of individuals and from the approach of different professions and agencies. Threlfall's work suggests that the apparent lack of clarity and distinctiveness, poor understanding about the social work role, inadequate interagency referral protocols, shortage of skills and experience among social workers, insufficient training, negative stereotypical views, and the demands of other work, combined to restrict social work potential in the care of disabled children during the 1970's.

Defining Roles, Responsibilities and Standards

Barclay (1982) made similar observations to Threlfall in his review of the roles and tasks of social workers. He also identified that the lack of clarity about social work created barriers to referral. Barclay sought to overcome this confusion by classifying social work into two parts: 'direct social work', which included 'assessment, practical help, surveillance and control, counselling, management, mediation, and support of voluntary effort'; and 'indirect social work', which included 'supervising staff and volunteers, training, planning, management, mediation, and community development' (1982:23). Barclay stressed that all aspects of the social work role are important - direct and indirect. He argued that if social workers did not undertake the distinct

tasks which these roles required, many of them would be left undone, which would be to the 'serious detriment' of those affected.

Barclay also identified specific tasks for social workers in interagency working. He argued that social workers should negotiate and advocate on behalf of clients in order to highlight their needs and, if necessary, to criticise and address service inadequacies. However, Barclay stressed that the fulfilment of these tasks required social workers to identify what might be claimed, and recognised by others, as the particular or 'unique' contribution of social work. He saw this as their 'prime responsibility... to promote respect for a client's dignity and worth', which requires them to take 'as much as possible of the complexity of another's life into account' (1982: 36). Barclay perceived that this approach constituted the 'underpinning philosophy' of all social work. He argued that because one specific group of workers carries this prime responsibility it allowed others to concentrate on their own 'particular contributions' (1982:36). This point is significant because it highlights the importance of social workers convincing other professionals that they can rely on them to fulfil this responsibility with competence.

Barclay argued that social workers should be equipped to undertake the roles and responsibilities required for social care planning and counselling for any client group in a basic but competent manner. He defined competency as: 'acquiring a wide range of knowledge and skills of a client group, or to be able to transfer knowledge and skills acquired with one group to another' (1982:153). Hence, he argued that social workers employed in multidisciplinary learning disability teams should be competent in dealing with any problems that might arise in their clients' families even though they may not be directly associated with the disabled family member. In this way, Barclay portrayed social workers as professionals with a wide repertoire of

transferable skills. He intended that his clarification of the social work role would enable other professionals (and service users) to make best use of it.

However, despite an increasing acknowledgement of the value of social work services and a consequent substantial growth in provision during the 1980s, others observed that the social work role continued to be unclear and even paradoxical (Gilbert 1985; Heddell 1988). Gilbert argued that although knowledgeable and caring social workers were much in demand, and were seen to be at the heart of multidisciplinary teams for disabled children, collaborative difficulties arose because 'the role the social worker is meant to fulfil often appears ill-defined' (1985:295). Gilbert considered that confusion about the social work role arose partly because others did not perceive social work to require any particular expertise or training. He also argued that there was an inadequate framework upon which to establish the basis for a social work service, because legislation demonstrated contradictory and confusing government concerns about societal care and social control. Consequently, the definition of the social work role in caring for disabled people appeared to depend more upon 'current pressures and professional attitudes' than good practice.

Besides these concerns there was also strong criticism of the failure of social workers and their agencies to provide families with the support they required. Thompson (1986), for example, argued that many authorities lacked social work services for meeting even the most fundamental needs of disabled children. She observed that despite the increased emphasis upon care in the community for disabled children, families were suspicious that they would simply 'be left to get on with it with as little help from the social services as they can decently give' (1986:212). It is a sad indictment that Thompson felt it necessary to advise parents to 'demand' help from the social

services, stating that 'we are entitled to their help and if we make enough noise we'll get it - if only to make us go away' (1986:212).

Evans et al. (1986) made similar observations through group work undertaken with parents of disabled children in Merseyside. As group work facilitators for a voluntary organisation they anticipated a need to provide families with help over time-consuming emotional problems, such as acceptance of their child's disability or overprotection of the child. Yet in fact, it was with practical problems that the parents most needed help. In planning the group work the authors had assumed that practical problems would be dealt with by the social services, yet they found themselves providing parents with financial guidance on benefits and voluntary funds, liaising for them with schools, hospitals and the social services, and obtaining information for them about their child's disability and prognosis. They argued that 'the time spent in these activities showed how poor was professional understanding of these parents' problems and the poor co-ordination of services' (1986:67).

A solution to these concerns, at least within children's services, perhaps lay within the gift of the Children Act 1989. The government drew together existing legislation relating to social services for children and families and, in the light of contemporary knowledge, prepared what they hoped would provide 'a legal framework for a new approach to provision of services to a child with disabilities.'

The Children Act 1989: a new approach to social work with disabled children

In the guidance that accompanied the Children Act (DoH 1991a), the authors argued that the key elements of 'sound-practice and multi-agency, multi-disciplinary co-operation' needed to combine and influence the policies, procedures and practice of professionals working with disabled children and families and thereby create a 'new approach' to service provision. It was intended that this approach would help social services, education departments and the health service 'to consider afresh their policies and strategies for the provision of services to children with disabilities' (1991a:1). The government suggested that existing collaborative mechanisms, such as Child Development Teams and Community Mental Handicap Teams 'may need reviewing and strengthening in order to ensure that young people have access to inter-agency expertise and provision' (1991a:50). The Act provided details about the nature and range of services which social services should make available for disabled children and families, and the roles and responsibilities social care staff were expected to fulfil in providing and commissioning these services.

Thus the Children Act and its Guidance provided detailed clarification about the roles and responsibilities of social workers and social services departments. By doing so, the government sought to resolve confusion about these matters and to clarify reasons and routes for referral. In summary, the role that the Children Act assigns to social workers requires them to be knowledgeable, skilled and competent in the following areas: carrying out holistic assessments of need in partnership with parents; assessing child development and understanding how various disabilities may affect a child; conducting individual social casework and family casework (with disabled children, siblings, and adults); communicating through different mediums with children who have special needs; responding to requests for various sorts of counselling; offering advice

and a consultation facility for other staff and services (such as in specialist, supervisory or management positions); contributing to the design of new services; identifying useful community resources, voluntary organisations and services for young adults.

The role also requires social workers to be knowledgeable about and concerned with advancing children's rights; anti-oppressive practice; the social model of disability; normalisation; integrated services and mainstream education. It requires social workers to be involved in child abuse investigations, to work alongside the police and to appear in court; and perhaps to be involved in recruiting, training and supporting foster carers, child-minders or support workers. Finally, social workers are required to be skilled collaborators, and knowledgeable about the roles and contributions of other professionals.

As well as specifying the breadth of the social work role in detail, the Children Act also substantially reinforced the central importance of the social work contribution to co-ordinating multidisciplinary assessment and care planning. The legislation reflected the increasing expectation that professionals should reach agreement about how families' needs for services could best be met, having listened to the child's wishes and feelings and established a partnership with parents, carers and each other. Furthermore, the particular value of social work skills in mediation and resolution were emphasised, because it was anticipated that taking everyone's views into consideration would lead to conflicting perceptions of needs between the child, their carer and different professionals.

If the Children Act gave hope that the criticisms of social work and social services would be brought to an end the early signs were not positive. Research conducted by the Audit Commission (1994) found that across the UK only 25 per cent of parents considered that the assessment arrangements for their disabled children had been well co-ordinated. So why had the

government persisted in emphasising the social worker's role in co-ordinating multidisciplinary assessment and care planning despite the evidence of enduring difficulties? Some clues about this can be found in Sir Roy Griffiths' (1988) examination of community care services.

The Rhetoric and the Reality

Griffiths (1988) had disclosed his concern at the lack of effective co-ordination of care planning for individuals. He also declared how struck he had been by the differences between arrangements for the provision of medical and non-medical care. He observed that if someone needs medical care they know that they should contact their GP who will make the necessary arrangements. Although he considered that it would be 'too elaborate and indeed inappropriate' for a similar system to be established for non-medical care, he nevertheless expressed his surprise that such a system involving 'the assignment of a person in need of support to an individual carer, so as to become his responsibility, is rarely made, even where it would be highly applicable...' (Griffiths 1988:10).

Griffiths seemed to be drawing attention to the continuing failure of social service organisations to act upon the repeated calls for a named person or keyworker to provide families with advice and support and to take responsibility for the monitoring, reviewing and co-ordination of care plans. However, this failure did not lead to an abandonment of the idea. It was revitalised and given even greater emphasis in the NHS and Community Care Act 1990 under the new guise of 'care management'.

However, Griffiths (1988) took a somewhat different stance towards the development of collaborative working to those who simply urged practitioners to learn about and appreciate each others' contributions. He looked instead to the processes, structures and resources that needed to

be in place. Griffiths perceived there to be a serious and long-standing split between policy and reality in community care. He argued that:

At the centre, community care has been talked of for thirty years and in few areas can the gap between political rhetoric and policy on the one hand, or between policy and reality in the field on the other hand have been so great. To talk of policy in matters of care except in the context of available resources and timescales for action owes more to theology than to purposeful delivery of a caring service (Griffiths 1988:iv).

Griffiths found evidence that the lack of resources was the most significant reason for failure in service provision and co-ordination. He argued that policy and resources had to come into a reasonable relationship if clarity was to be achieved about service goals, and if leadership and direction were to be given to those providing services. Griffiths' arguments are significant because they highlight how the gap between the social work role and the reality of what they are seen to achieve for families may arise from unrealistic expectations in view of high workloads, inadequate resources and poor management. These insights are valuable in showing how social work's potential to provide satisfactory services can be impeded, regardless of the skills of individual workers, if significant structural factors are not addressed.

Griffiths' arguments greatly influenced the development of the NHS and Community Care Act 1990. When this legislation was introduced the Government stressed that the Children Act and the Community Care Act should be seen as 'consistent and complementary' and 'taken together in setting a fresh agenda and new challenges for social services for the next decade' (DoH 1991).

The NHS and Community Care Act 1990

The challenge and agenda for community care is to provide a range of services that are 'responsive, flexible and sensitive to the needs of individuals and their carers' (DoH 1989:1.10). And the 'cornerstone of high quality care' is effective interprofessional co-ordination of assessments and care plans.

The Act established new assessment arrangements, which involved significant changes in the way professional workers were expected to operate. Care managers, employed by Social Service Departments were given responsibility for arranging assessments, designing, co-ordinating and reviewing care plans, tailored to the needs of the individual, in collaboration with other relevant professionals. The government stressed the importance of a co-ordinated approach to collaborative care, and of care managers developing the necessary skills for this way of working:

A single individual should be responsible for ensuring that each case is dealt with effectively. Indeed, an essential skill which case co-ordinators will need to deploy will be to manage the involvement, contribution, co-operation and partnership between the Local Authority and other authorities and professionals involved in providing services. The government expects all those concerned to contribute positively to such arrangements (DHSS 1989:3.2.7).

Thus the Children Act 1989 and the Community Care Act 1990 urge professionals to take a collaborative approach to assessment and care planning for disabled children.

Dale (1996) suggests that because a wide range of different professionals and service providers are required to meet the majority of disabled children's needs, the legislation and policy guidance expects that care management will almost always be multidisciplinary. Dale considers that the social worker's contribution to this multidisciplinary approach includes ensuring that assessments consider the whole family's needs. She also argues that social workers

are responsible for ensuring that assessments are 'individualised' (recognising that each family has its own needs) and 'time-specific' (recognising that needs change over time). Dale argues that social workers can overcome difficulties in achieving co-ordinated and individualised assessments if they adopt a model wherein they facilitate a process of 'negotiation' between the family and professionals in identifying the family's needs. This point is significant in highlighting the importance of social workers developing a repertoire of collaborative skills, as discussed in Chapter 2, if they are to overcome collaborative difficulties.

Thus, the key components of the social work role include communication with disabled children and families, holistic assessment of families' needs, and co-ordination of multidisciplinary care plans, and it seems that the potential to fulfil this role arises from the particular knowledge, skills and values learnt in training. However, uncertainty amongst other professionals about social workers' abilities in child disability work seem to arise from an apparent lack of social work competence in dealing with the problems faced by disabled children and families. Social workers attribute this practice weakness to inadequate training and insufficient experience; and there is substantial evidence that the demands of other child care work overshadow that of disability work. However, there is also evidence to suggest that social workers have neglected important aspects of their role with disabled children in the belief that others can undertake the tasks as well as them. This suggests that they might not appreciate the importance of their contribution, when efficiently performed, for disabled children and families, or the value of the distinctive ways in which they can help clients. The discussion that follows considers how the use of the social model of disability as a framework for practice with disabled children can reveal that which is particularly distinctive and important about the social work role.

The discussion begins by exploring how particular ways of thinking about disability are reflected in language.

Language as a Reflection of Thinking

During the 1980's, disabled people from lay and self-advocacy movements, like the 'Advocacy Alliance' and 'People First', called for professionals to use language that focused on describing the abilities, personalities and circumstances of disabled people, rather than their difficulties and diagnoses. The disability movement considered it the responsibility of those enlightened to the importance of language to challenge those who were not, especially those who retained old expressions that seemed to label and devalue disabled people (Williams and Shoultz 1984; CMH 1989). They highlighted, for example, how children and adults felt insulted by the term 'handicap', and particularly by the phrase 'mental handicap', which seemed indiscriminate and too easily confused with mental illness. The disability movement argued that although professionals' awareness of how language can affect the relationship between disabled and non-disabled people had improved significantly, many of them persisted in using language that had the effect of stigmatising disabled people. This was due either to a lack of understanding, or because of resistance to change (Murray 1983; CMH 1989).

Some organisations responded to the disability movement by changing their terminology and perhaps most significantly - because of their public profiles - their names. For example, the 'Campaign for the Mentally Handicapped' - the organisation that arranged a series of successful conferences for disabled people during the early 1970's, and spearheaded the establishment of self-advocacy groups and the 'People First' movement throughout Britain - responded to calls

from their members to change their name to 'Values into Action'. Similarly, in the mid 1990's the 'Spastics Society' changed their name to 'Scope'.

However, some writers argue that these changes in terminology do not always demonstrate a change in thinking about disability. For example, Middleton (1996) and Morris (1997) both consider that despite the changes a lack of understanding has been evident in the language used by government and professionals to describe the situation for disabled children.

Disabled Children or Children with Disabilities?

The term 'children with disabilities', used within the Children Act 1989, was arguably appropriate when the legislation was prepared. It appeared to place the child foremost in the reader's thinking and thereby reinforced the concept of 'children first' - in which the fact of childhood should take precedence over the fact of disability. Use of this concept was an attempt by the authors of the Children Act to acknowledge how the rights and needs of disabled children had been overshadowed by a focus on their disabling condition. The term 'children with disabilities' was also in common usage among practitioners who considered it to have constituted a very important shift away from stigmatising expressions such as 'the handicapped'.

However, Middleton (1996) considers that the expression 'children with disabilities' suggests thinking about disabled children that is based on a narrow and unhelpful perspective. She argues that the expression is fundamentally misleading, because it gives the impression that disability is part of the child, rather than the result of attitudes and environments that restrict the child from normal childhood experiences. Similarly, Morris (1997) argues that the expression inhibits recognition of the social context in which children experience their particular impairment. The term 'disability' in this context suggests that it is the child's impairments (their

functional limitations), which alone affect their ability to take opportunities that would otherwise be open to them.

These writers argue that the preferred term ‘disabled children’ should indicate thinking that recognises how a child’s ability to experience fulfilment in life can be affected in a detrimental way by the attitude and behaviour of others. This includes the lack of facilities and resources that could enable them to overcome any personal difficulties they might have as a result of their physical, sensory or intellectual impairments. This is now generally understood as thinking through the perspective of a social model of disability, (or similarly an ‘ecological’ or ‘empowerment’ model). This is the model for practice that disabled people have themselves called for. The social model is often contrasted with the medical model of disability (alternatively known as an ‘individual’ or ‘institutional’ model). The next section explores these contrasting models and considers their relevance to social work practice and potential in child disability work.

Contrasting Models of Disability

Morris (1997) explains that those who use the medical model of disability define problems in terms of individuals’ intellectual, physical or sensory impairment. Consequently, solutions to these problems are considered to lie in how individuals might be ‘treated’, ‘changed’, ‘improved’ or made more ‘normal’. Morris argues that this way of looking at children’s situations is based on the premise that they are alterable, while society is fixed.

Within the social model, however, disability refers not to impairment, but to ‘the social factors which create barriers and deny opportunities and thereby dis-able people.’ These factors include ‘prejudicial attitudes and institutional discrimination, such as the failure of schools to

provide the kind of support and facilities that children with impairments require' (Morris 1997:242). Morris argues that these barriers are evident in a great deal of research and policy development, where the definition of disability informing the work has been based on a medical model. Consequently, the work focuses on the perspectives of parents and providers and is insufficiently concerned with children's own experiences.

Loxley (1997) also contrasts medical and social models of disability and in doing so highlights the contribution of social work to widening the dimensions by which disability is understood. Loxley argues that the current model of disability used by health professionals is the 'Bio-psycho-social model'. This model has developed from a traditional 'Bio-medical' model, wherein illness was thought to have a specific cause that could be identified, treated and cured. Through the influence of psychology and psychoanalysis, the role of the medical practitioner has widened to encompass that of an educator and counsellor (psychotherapist) seeking to 'induce peace of mind' in the patient. Loxley highlights the close association between these developments and the idea of 'whole person' or 'holistic' medicine. However, she argues that this 'medical understanding' of 'social' is generally confined to an individual or family perspective, and equated with 'cultural' factors. She identifies that the early development of social work was similarly based on a model of welfare as it related to individuals and families or at its widest a neighbourhood community. However, by the mid-twentieth century, social workers recognised this to be inadequate for effective intervention in many of the social problems experienced by their clients (such as poverty and poor health). Thus, a wider understanding of 'social' has developed, which includes economic and political dimensions, and which is equated with 'structural' factors.

However, Loxley considers that while social workers and managers may recognise that this understanding is at odds with the clinical orientation of medical practice, ‘they largely feel themselves powerless as professionals...to engage in [anything] other than the traditional professional spheres of intervention’ (Loxley 1997:30). This point is significant because it shows how social workers need collaborative skills to advocate for disabled children in an area of work where medical leadership is largely assumed, and which is largely dominated by the medical model and long established methods of intervention.

The work of these writers suggests that social workers could overcome certain collaborative difficulties and practice weaknesses if they made explicit use of the social model of disability. This requires them to have confidence in their goals and to be capable of explaining their work for others. Loxley highlights how such skills are particularly necessary for social work practice in care management. Community Care policy was based on the idea of normalisation, which developed into the philosophy that the goal of care is to enable and empower clients so that they participate in the assessment of their needs and the management of services. Loxley argues that for this to happen clients require access to information and resources and the power to choose. This approach reveals that ‘The ideal model of community care is therefore a complete contrast to the traditional medical model of the powerful expert and the passive patient’ (Loxley 1997: 32).

Ignorance, Prejudice and Discrimination

Middleton (1996) argues that it is essential that professionals recognise that disability derives not simply from a child’s impairment, but from the complex reactions that people have to it. She observes that many people’s day-to-day attitudes and behaviours toward disabled children

demonstrate a lack of respect for them as children. She argues that the contexts in which professionals conduct their assessments and arrange services are often characterised by prejudice and discrimination. Middleton considers that this situation reflects the lack of influence of the United Nations Convention on the Rights of the Child and the Children Act 1989 compared with more powerful folklore about disability. However, she suggests that there is a great deal that can be done to counter this:

By emphasising the fact of childhood first, rather than the disability, and by responding to the child's personality rather than their diagnosis. In doing this the child is enabled to become central to the picture, and their experience of prime importance and value, displacing the medical practitioner as the source of expertise (Middleton 1996:63).

The government have recently demonstrated its support for this approach. They have asserted in the new 'Framework for the Assessment of Children in Need and their Families' that the spirit of the Children Act 1989 is in harmony with the social model of disability (NAfW 2001). Evidence of this can be found in the strong focus placed on children's rights, holistic assessment, integrated service structures, access to mainstream provisions, and in the particular importance given to professionals understanding each others' roles and working closely together in assessment and care management.

Social workers have particular responsibilities under the Children Act, and the new assessment framework, for combating discrimination and highlighting where the behaviours of others or the structure of services create disabling barriers that prevent children from participating as equal members of their community. The arguments of the writers cited in this chapter suggest that social workers can only fulfil these responsibilities if they participate in multidisciplinary arenas and challenge, where necessary, the traditional medical and institutional models of assessment and service delivery. The social model of disability can provide social

workers with a framework to guide such challenges and to support the alternative interventions that they propose.

However, there is evidence that social workers themselves lack sufficient understanding of the social model of disability (Middleton 1996). Furthermore, their insight concerning the needs of disabled children and families is inadequate for them to achieve much influence in multidisciplinary arenas (Browne 1982). Browne (1982) and Middleton (1996) have both argued convincingly that the failure of social workers to gain the understanding required to fulfil their primary roles arises from their own discriminatory attitudes and a lack of commitment to disabled children. These assertions are significant for this thesis because they indicate significant weaknesses in social work, which militate against its potential in this field of work. These matters are explored further in the following discussion of the importance of integrated service provision for disabled children. The discussion considers how using the social model of disability to inform practice and organisational arrangements for social work services can help social workers and their agencies to develop accessible and integrated services for disabled children and families.

Achieving Social Integration

Local Authorities are directed by the Children Act 1989 Guidance and Regulations (DoH 1991a) to develop their services so that they minimise the effects of children's disabilities. The Act expects social workers to ensure that disabled children have access to the same range of services as other children. Thus, the Guidance states that 'every effort should be made to work collaboratively in team and multi-agency structures in order to avoid the creation of separate and segregated services' (DoH1991a: 1.5). These principles concerning integrated service provision

are reinforced by the UN Convention on the Rights of the Child, which the British government ratified in 1991. Article 23 pronounces that parties to the Convention:

Recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community (1989:Article 23).

While the Convention recognises the right of disabled children to special care, the principle requires providers of such care to maximise children's opportunities for social interaction. Signatories to the convention endorse a pledge that the services they create to support families in meeting the special needs of their children shall:

Be designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual development (1989:Article 23).

The importance of integrated services for disabled children is therefore two-fold: to ensure their equal access to mainstream community services, and to facilitate their social integration and active participation in society.

The British Association of Social Work (BASW) praised the government for embracing the principles of integration and collaboration within the Children Act 1989. They argued that the legislation served to remind local authorities of their 'long standing duty' to disabled children under existing statute (BASW 1992c). However, they were sceptical about whether local authorities would put the principles into practice. While promoting qualified social workers as key contributors in this, the Association expressed serious concern that 'the priority given to other aspects of children work will continue to overshadow the real needs of children with disabilities.' This publicised concern shows how BASW tried to highlight the importance of organisational structures and resources in supporting social workers in their role.

The Welsh Office Social Services Inspectorate (SSIW) were mindful of these concerns when they undertook an examination of the arrangements for providing services to disabled children throughout Wales (Welsh Office 1991). The Inspectorate were particularly interested in how social service departments organised their services so as to make them accessible for disabled children and families. The report of this inspection provides some helpful pointers in identifying the arrangements that can best support social workers in overcoming collaborative difficulties.

Accessible Services for Disabled Children

In reporting on their inspection, the SSIW stressed that local authorities had a duty to fulfil the primary aim of ‘promoting access for all children to the same range of services.’ They also highlighted authorities’ duty to develop a ‘specific policy’ on the integration of their services (Welsh Office 1991). The Inspectorate asserted that the organisational arrangements for delivering social care services should contribute to the achievement of these important objectives.

The inspection team analysed organisational arrangements for child disability services using a framework that facilitated examination of case responsibility at practitioner level, and the management and processes available to support integrated service provision. They identified a wide variety of methods by which local authorities organised their social work services for disabled children. The four most prominent methods entailed case responsibility being held within generic teams; in child care teams; in disability teams working with people of all ages; or in disability teams working solely with children and families. However, the inspectors found

that, regardless of the method used, disabled children and families faced difficulties accessing services in all the Welsh counties.

The problems arose mainly because different sections of departments held responsibility for different services. So, for example, if a generic disability team carried case responsibility there would always be another reference point for the family because some services were only accessible through children's teams. Thus, if a child had needs directly related to their impairment one team dealt with these, but if their needs concerned an indirect issue, such as child protection or other matters involving child care legislation, then a different team dealt with these. Hence, the Inspectorate found that when detailed 'child care knowledge' was required, as opposed to 'disability knowledge', families were likely to be transferred to another team.

Mainly because of these disjointed service arrangements, the Inspectorate found the structures throughout Wales to be unsatisfactory.

Knowledge about services available to children with any disability and services available to any child, with or without a disability, appeared patchy raising further doubts about access. Children with a disability seemed most likely to gain access to general services for children if there was a child protection issue or they were subject to a court order (Welsh Office 1991:5).

The SSIW concluded that 'boundaries seemed to be acting as barriers.' They found communication difficulties between service areas, a lack of understanding between services, and limited knowledge within some services about the importance of accessibility. These problems all created barriers within social services' own organisational arrangements, which limited access for disabled children and families and caused the service to be disjointed. Furthermore, these difficulties created confusion for other professionals about social work services; they did not know to which team they should refer. These findings are significant because they show how agencies can impede collaboration between and across organisational boundaries if they do not

consider the efficiency of the structures and processes through which social workers take referrals and arrange services. Alternatively, the findings show how agencies can assist social workers in achieving their potential and overcoming difficulties if their supporting structures and processes are efficient. The following discussion explores the forms that these arrangements could take.

Specialisation within Mainstream Services

The SSIW argued that social services could resolve the problems identified in their inspection, and the consequent practice weaknesses, if they accorded disabled children 'priority as a distinct group of children in need.' They proposed that, having established child disability work as a priority, the agency should ensure that a degree of specialisation is available so that 'workers with knowledge and expertise in the field' could provide assessment, counselling, advice and information services. While not opposed to the idea of specialist teams, the Inspectorate judged that the appointment of specialist workers within child care teams would enable workers to call upon their knowledge and skills most efficiently.

The SSIW considered that whichever method of organising services an agency chose, its success should be appraised against its capacity to include:

One clear reference point for the child and family, whatever they identify as the issue for them; readily available knowledge and skill to assess and address needs arising from disability, childhood, parenting or family life; access to opportunities to enjoy ordinary experiences of childhood... access to the full range of services available to meet needs arising from disability and from aspects of childhood (Welsh Office 1991:39).

The SSIW considered it most likely that mainstream child care teams would have the greatest capacity to include these features. This method of organising disability services within child care teams, with specialist workers available, had been advocated by Browne (1982) and

has since been argued by Middleton (1996). These writers consider that service provision through mainstream child care teams is most likely to ensure equal access to services for disabled children; with the added benefit of providing child care social workers with opportunities to develop their understanding of disability.

These arguments are significant because they propose solutions to practice weaknesses and collaborative difficulties in social work. They suggest that social workers can address concerns about their poor understanding of the needs of disabled children and families through casework, and that they can improve the standard of their interventions through guidance from specialist colleagues. If social workers could provide families with the service that the Inspectorate describe in the quotation above, it is likely that this would also enable them to overcome some of the difficulties they have in collaborative working. Such a service would provide other professionals with a convincing demonstration that social workers have the appropriate skills and can supplement their knowledge to meet the specific requirements of disabled children and families. However, the evidence presented here could be interpreted another way. The SSIW made their recommendations a decade ago, and Browne made hers some twenty years ago. At that time, Browne expressed serious concerns that if specialisation was not used as a stepping-stone to the goal of full integration then weaknesses in the social work service would continue and the profession's role could be lost. Sources identified in the earlier chapters of this study showed that these weaknesses in social work practice have persisted, both in collaborative working and in meeting the needs of disabled children. These findings suggest that the social work potential to overcome these difficulties is failing. And the evidence of this chapter is that this failing is due in part to the lack of supporting structures and processes. Nevertheless, this thesis maintains that social work can play a convincing and leading role. The

evidence for this may be found in specialisation, which arguably holds advantages for the development of social work expertise and positive interprofessional relationships.

Mainstream or Specialist Services?

The issue of whether local authorities should provide specialist social work services, as opposed to integrating the required knowledge and skills within mainstream child care services, is a complex one. On the one hand there are advantages in employing social workers with the kind of expertise derived from experience and maturity, who can advise others and manage skilfully the interpersonal and interprofessional dynamics within specialist settings alongside specialist workers from other agencies (Craft et al. 1985). On the other hand, social services need to ensure that disabled children are not 'disregarded' by mainstream child care social workers and simply referred on to 'the specialists' (Middleton 1996). Browne (1982) observed that this concern presented a significant challenge to social services in the face of high levels of child protection, juvenile delinquency and statutory child care work. She concluded, somewhat reluctantly, that her survey of social work with disabled children in Northern Ireland revealed compelling arguments in favour of a certain measure of specialisation. She argued that the long history of 'low priority and status' accorded to disabled children in social work meant that a period of positive discrimination through specialisation was both demanded and justified. Furthermore, an incremental approach to the development of skills and structures was necessary if serious and entrenched difficulties were to be overcome. With particular concerns for children with intellectual impairments, Browne argued that:

The apparent failure of qualified social workers to supplement and transfer the knowledge and skill used in family and child care work to situations involving the mentally handicapped child and his family is a source for concern (1982:84).

Browne reasoned that appointing specialist workers was one way of ensuring that disabled children and their families would get the recognition and support they deserved. However, she argued that the best place for specialist workers was within child care teams, rather than separate specialist services. In mainstream child care teams they could encourage other workers to develop the knowledge and skills necessary for child disability social work, and they could carry responsibility for matters requiring particular expertise. Browne identified these matters as helping children with severe behavioural disorders and liaison with teachers. She highlighted these matters because other professionals were most critical of the lack of social work skills in these areas, and parents considered them among the most important matters for which they required advice and support (Browne 1982).

A decade after Browne's work, BASW (1992c) also argued that if local authorities were to adhere to the principles of the Children Act 1989 they should arrange to meet the needs of disabled children within mainstream child care services. They considered that several specialist reference points could be less rather than more helpful for families, and they supported the view that families should be able to access all the services they require from one point of reference. BASW asserted that social workers possess the knowledge, skills and values necessary to carry all the powers and responsibilities of the social services and education welfare and to provide families with a holistic service. All that they required was the structures and resources to support them.

These arguments from Browne, the SSIW, and BASW are helpful in contributing to an understanding of the complexity faced by local authorities in deciding how to organise social work services. Specialisation, perhaps through multidisciplinary teams, offers advantages for interprofessional working and enables some workers to develop expertise in child disability

work. However, problems can arise from the inevitable service fragmentation that results from developing separate specialist services. The middle way, of providing some specialisation within mainstream child care teams, appears to provide a solution to these difficulties. However, there are other matters to consider, which Middleton (1996) brings to the fore.

The Dangers in Specialisation

Middleton (1996) provides some further insight into how agencies might best structure social work services to meet the needs of disabled children and to enable social workers to fulfil their potential. She argues that while parents may prefer a specialist team because they see it as representing expertise and commitment, what really matters to them is the attitude and values of the workers and the availability of information and resources. Thus, she argues, it is important not to confuse the 'status' of a team with the service they offer. Furthermore, there are dangers that if a specialist team routinely recommend specialist services they may perpetuate the marginalisation of disabled children.

Middleton identifies weaknesses in the view that the expertise of specialist workers enables them to form positive professional relationships, particularly with medical personnel. She argues that any competent social worker should be capable of developing such relationships, and that specialist workers risk assuming an out-dated 'handmaiden' approach towards consultants, which leaves doctors setting a medically led agenda.

Some writers argue that as specialists develop their knowledge and experience they also learn about interdisciplinary links and hence become more effective in collaboration (McGrath 1992; Craft et al 1995). However, Middleton finds that this view is based on the argument that many social workers do not stay long enough in their jobs to develop a 'genuinely generic

approach'. She argues that this situation is no different to any other aspect of child care work. She argues that such a view risks perpetuating segregated services and absolving other social workers from including disabled children in their thinking. This position is particularly persuasive when she argues:

The plea of most social workers that they cannot work with disabled children because they cannot communicate is often made and is a thin disguise for disablism. This 'out of sight, out of mind' approach of organisations to disability is pernicious and damaging without actually being overtly hostile. It ensures no progress is ever made down the main line by steering disability issues into a siding (1996:25).

In Chapter 2, there was evidence that the scope and volume of responsibilities carried by social workers in children's services inevitably leads to failings. Middleton reports that practitioners often argue that the needs of disabled children just cannot compete with the demands of child protection work and perhaps therefore it is better that they have a specialist service than none at all. However, she identifies dangers in this line of thinking because it suggests that disability work and child protection can be seen as 'mutually exclusive'.

Middleton cautiously proposes temporary stepping-stone solutions to this 'all or nothing' scenario, which are similar to Browne's (1982), and which she bases on effective collaboration. She argues that either child care teams should designate a member to carry a specialist disability brief, or the child care teams and the specialist services should establish very close working relationships. In both these situations, Middleton argues that the specialists should be available to advise child care workers, and joint working should be encouraged to help social workers transfer their knowledge and skills so that they all become more generic.

However, weaknesses have been identified in both these positions, which suggest that the ultimate goal must be fully integrated services. For example, Middleton (1996) reports that in

teams where one member has a specialist brief they often become isolated from their teams and look for support links elsewhere. This can lead other workers in the team to consider themselves acquitted from thinking about disability. Similarly, where agencies have established specialist teams, members have reported feelings of isolation, not simply from the child care teams but also from their department. Rather than feeling 'special' these workers often have a sense of being marginalised as a low priority. Middleton has found this reported even where specialist teams are well resourced. This, she argues, is because the workers have a sense of 'being peripheral to the real aims of the department and of dealing with work which nobody else wants, or considers important' (1996:26).

These points are significant because they provide some insight into why, despite increasing use of specialist workers by local authorities, many families still have difficulty accessing services and continue to experience poor co-ordination of their assessments (Collins 1995).

Conclusion

The literature reviewed in this chapter has identified how the social work role has evolved in recent decades. The key components include communication with disabled children and families, holistic assessment of families' needs, and co-ordination of multidisciplinary care plans. The discussions suggest that the social work potential to fulfil these tasks arises from particular knowledge, skills and values developed through training.

The discussion has revealed three key themes concerning what impedes social work from collaborating effectively and fulfilling their role competently. First, there are uncertainties among other professionals about social workers' abilities in child disability work, which prevent

them from making referrals to social work. These uncertainties arise from evidence of the lack of social work competence in dealing with the problems faced by disabled children and families, which social workers attribute to inadequate training and insufficient experience. This links with the second theme, that local authority resources and social work efforts have become increasingly focused on the considerable demands of child delinquency and child protection work. These demands are such that social workers have to cope with complex and heavy caseloads while facing unrealistic expectations about what they can achieve. However, a third theme connected with this is that social workers have neglected important aspects of their role in the belief that others can undertake the tasks as well as them; and they have failed to appreciate the importance of their distinctive contribution for disabled children and families.

The discussions in this chapter suggest that even where professionals adopt holistic or bio-psycho-social models to inform their practice, their understanding of disability and their interventions may still be dominated by traditional and medical approaches. The discussions also reveal that insightful and skilful use of the social model of disability - and the values that underpin it - to inform practice can assist social workers in fulfilling their role and potential in the collaborative care of disabled children. Furthermore, such a way of working could arguably be seen as distinctive to social work.

The discussions also reveal a consensus among commentators that the best way for agencies to organise social work assessment and care management, so that social services are accessible for disabled children and families, is to provide them through mainstream child care teams. Moreover, organising services in this way provides social workers with opportunities to gain experience of working with disabled children and to develop their knowledge and skills. A degree of specialisation or expertise may also be helpful in dealing with particularly complicated

situations for families, and as a source of advice for other workers. However, the literature explored in this chapter has served to highlight how there is no justification for social workers to treat disabled children any differently to other children; the skills required for helping disabled children are much the same to those used in other areas of child care. Thus, if specialisation is used it should be for the right reason, which is to further the goal of fully integrated and accessible services for disabled children.

The chapter has revealed several matters concerning the realisation of social work potential. The first concerns organisational structures and processes. For social workers to collaborate effectively in meeting the needs of disabled children and families they need their agencies to provide organisational arrangements that support this way of working. The discussion in Chapter 2 of models for collaboration highlighted the significance of agencies' commitment in this respect. The discussion demonstrated how competence in collaborative work requires commitment from all parties to develop services that others can trust to provide consistent and predictable standards (Loxley 1996).

This links with the second matter concerning the importance of social services prioritising disabled children as a distinct group of children in need. The SSIW (1991) considered that giving disabled children priority in social work, and thinking about how best to meet their distinct needs, constituted the first steps in addressing practice weaknesses and collaborative difficulties.

The third matter concerns discriminatory attitudes towards disabled children in social work. Middleton's (1996) argument that child care social workers make excuses for avoiding work with disabled children raises concerns about social work commitment to 'professionalism'. The integration of child disability work within the mainstream may help tackle avoidance arising

from a lack of confidence by providing social workers with opportunities to develop their capacity to respond to the needs of disabled children and families. This could help bring about a greater realisation of social work potential, which might in turn raise the estimation of social workers in the eyes of other professionals and help them to overcome difficulties in collaborative working. However, such developments would be impeded if avoidance were due to discrimination and a lack of professionalism. Because of the significance of this issue for the main thesis, the issue of professionalism in social work is discussed in detail in the next chapter.

The key to addressing the matters raised above may lie in social workers and their agencies investing similar time and effort into developing practice with disabled children as they have in changing practice in child protection work (Middleton 1996). The next chapter's discussion of social work professionalism considers the implications of this idea, which is explored also in the thesis conclusions in Chapter 9.

Chapter 4

Social Work Professionalism

Introduction

This chapter explores two things: first, the question of how far an actual commitment to ‘professionalism’ and a discernible improvement in specialised skills or expertise is required to fulfil social work’s potential in the care of disabled children. Second, the chapter explores how far other professionals’ views of the professionalism of social work have had an impact on the social worker’s role and contribution in collaborative working.

Professionalism is significant because it is the chief mode of occupational organisation for the various health, education and social care professionals who collaborate in care planning for disabled children. Thus, important features associated with professionalism characterise the context within which relationships between practitioners are developed, and in which the child’s plan is enacted.

The first part of the chapter examines some historical perspectives on the meaning and relevance of professionalism in the modern occupational structure of health and welfare services (Parsons 1968; Larson 1977). This includes an examination of attempts made to achieve an agreed definition of professionalism (Waddington 1996). Consideration is given to the actions taken by social work to professionalise and to persuade others of their professionalism (Butrym 1976; Jones 1979; Payne 1996). Some critical perspectives are examined wherein social work is accused of construing the picture of their professionalism for their own gains rather than for the cause of their clients (Friedson 1970; Johnson 1972; Parry and Parry 1979; Abbott 1988).

For the purposes of this debate, professional status is considered to be a reflection of recognition from others of the commitment and expertise required and demonstrated by social workers in dealing with complex practice situations.

In collaborative working, practitioners have expectations of each other that are influenced by their understanding of professionalism and the importance they attach to specific features of professionalism. This chapter examines those features that are most significant for social work: competence, expertise, autonomy and authority. Some consideration is also given to the significance of education and training, which is explored more fully in the next chapter.

It is acknowledged that the relevance others give to these aspects of professionalism, and to social work status, will vary. Others' views will depend on personal perspectives developed through practice experience. These perspectives may be further influenced by the way social work is portrayed to them during training. In collaborative care for disabled children, the common features that characterise the different professions may mean that practitioners carry similar status and authority. They may take the view that similar rules have been applied to their occupations in achieving professional status, and that individuals have fulfilled similar conditions in obtaining qualifications. This chapter shows that where other professionals attach particular significance to differences in status, or where they are critical of social work professionalism, then this will impact upon collaborative relationships and the efficiency with which the child's plan can be co-ordinated. Therefore, the second part of this chapter explores some of the differences and weaknesses that other commentators have highlighted as affecting social work (Richan and Mendelsohn 1973; Hornby 1993; Payne 1996).

Other factors that can affect social work status are also explored; these include the dominance of the individual/medical model within disability services and the relatively low

status of disability work in welfare agencies. It is proposed that for social work potential to be fulfilled it is necessary for workers to take up the challenge of addressing these matters and current weaknesses in practice. The discussion concludes that this endeavour requires social workers to be committed to clients, to develop specific knowledge, skills and values for working in collaborative care for disabled children, and to command greater authority and enhanced status through the demonstration of specialised skills or expertise.

An Historical Perspective on Professionalism

The term profession was first used in pre-industrial Europe to describe those occupations in which individuals without any source of 'unearned' income could make a living outside manual work or commerce. The classical professions were law, divinity, medicine, and to a lesser degree army and navy officers and architects. Larson (1977) shows how tracing the history of professions back to the rise of institutionalised centres of learning in medieval Europe, that is, to universities, reveals the point at which the older 'learned' professions (or 'specialists for the elite'), separated from the 'craft guilds' (or 'practitioners'). The association that the learned professions established with universities, in combination with their knowledge of Latin and their links with the Church, gave them 'elite' qualities, which distinguished them from their specialist counterparts in the guilds (Larson 1977).

The craft guilds developed in the towns between the eleventh and thirteenth centuries and, with the rise of urban markets, many of their specialist practitioners went on to appear as free artisans and tradesmen whose orientation was primarily commercial. However, some of them were also found in master-servant relationships within the households of noble, rich and aristocratic patrons. Larson (1977) argues that these arrangements were significant in

influencing the nature of relationships that developed later between workers and employers within the modern professions. She observes that in Great Britain:

These pre-professional specialists survived the decline of the craft guilds and, as the “lower branches” of medicine and the law, played a dynamic part in the nineteenth century constitution of the modern professions (1977:3).

The French Revolution played an important part in influencing the development of the modern professions by signifying to the world that careers should be open to talent, although this ideal did not really take off until the rise of industrial capitalism in the mid-nineteenth century (Larson 1977; Wilding 1982). However, the subsequent changes that arose, whereby careers could be developed by merit rather than by birth and patronage, led in Britain to professional career patterns, which opened up for the middle classes the possibility of gaining status through work. This point is significant because these developments held particular importance for women and the status of work in which they held particular interest, including the health and welfare of children and families (Wilding 1982).

Defining Professionalism

While opportunities for professional careers broadened, disagreements arose about the definition and interpretation of professionalism. In the 1930s, sociologists attempted to define the elements of professionalism using a trait or check-list approach. However, this did not lead to any widespread agreement. Waddington (1996) explored Millerson’s (1964) review of the literature concerning professionalisation, in which 23 elements were listed, which had been included in the definitions of 21 writers. Millerson found that no single item was considered essential by every writer, and that no two writers agreed about which combined elements could constitute the defining characteristics of a profession. However, the traits cited most frequently

were: provision of formal training; possession of skills based on a distinct theoretical knowledge base; examination of the competence of members; adherence to an ethical code of conduct; organisational identity; and altruistic service.

Parsons (1968) sought to integrate and explain these features through an historical and functionalist perspective. He observed the boundaries of that which constitute the professions to be fluid and indistinct, with many borderline groups whose professional status is equivocal for a variety of reasons. However, he argued that the core criteria of professionalism were relatively clear when placed alongside a general categorisation of occupation roles. These criteria were identified as:

The requirement of formal technical training accompanied by some institutionalised mode validating both the adequacy of the training and the competence of trained individuals... the training must lead to some order of mastery of a generalised cultural tradition, and do so in a manner giving prominence to an intellectual component... not only must the cultural tradition be mastered in the sense of being understood, but skills in some form of its use must also be developed... a full-fledged profession must have some institutional means of making sure that such competence will be put to socially responsible uses (Parsons 1968:536).

It is useful to examine Parsons' perspective further as it provides insight into some of the factors that have affected social work in the process of professionalisation.

A Functionalist Perspective on Professionalism

The professions had traditionally been organised around the intellectual disciplines - the humanities and sciences - with the relationship between them and their significance to modern societies and cultural systems being centred upon universities and research institutions. Parsons (1968) considered that the modern phase of development in this 'professional system' had two

major focuses: the development of the modern university, and the demand for and capacity to use university-level training over a wide range of practical affairs.

Parsons described the development of professional training within the university system - which began in the late nineteenth century with the establishment of law and medical schools - as a 'new level of intellectual sophistication'. He considered that this led to a pattern which extended so far that 'a major credential of a new applied profession is the acceptance of its training program within the university framework' (1968:542).

It was increasingly recognised that applied science, taught through the academic institutions, could make unique contributions to public welfare. Parsons observes that law and medicine provided a framework within which the more elaborate system of 'applied professions' began to proliferate. From this institutional centre the professions were seen to be concerned with elements of the 'cultural system' other than intellectual disciplines, e.g. religion, the arts, morality and ethics. They were also concerned with the 'application of knowledge' to practical affairs, with the interests involved being both social and psychological.

These two strands - intellectual discipline and application of knowledge - later became differentiated, leading to the core of the professional system resting in two areas: the institutionalisation of the intellectual disciplines, and the practical application of the disciplines. This in turn led to two primary categories of professions being central to the modern system: the profession of learning (learning through research and scholarship; and educating others); and the applied branch of the professions.

Parsons (1968) considered that social work took its place within the applied branch of the professional system, alongside teaching and psychology. Each of these occupations had advanced significantly through the insights derived from psychology, from its probing of the

biological sciences (in examining the problems of the individual as a member of society), and sociology (in considering the individual's personality within the social structure).

However, Parsons (1968) argued that these three occupations were in a state of 'partly developed professionalisation'. Furthermore, he identified serious limitations upon the extension of professionalisation in social work due to its particular difficulties in applying theoretical knowledge. These difficulties, he argued, arise because social workers deal with so many 'diffuse intangibles' (including the basic uncertainties of changing situations in complex environments), and because social work practice entails 'playing it by ear' rather than applying 'codified rules or definitions of essential technical knowledge'.

Hence, from a functionalist perspective, further professionalisation in social work depends on the development of knowledge that can reliably be applied in practice situations. While the difficulty in achieving this is without question, the argument that it is a necessary feature indicates the dominance held by positivist science concerning how theoretical knowledge and applied skills should be developed. However, the value of positivism in social science research has increasingly been questioned, and alternative approaches have been developed that can generate reliable theories for application in social work. Kitwood (1990), for example challenges the dominance of positivist science and creates a convincing argument that, despite the difficulties, social science research can be recognised as 'professional'.

Challenging the Dominance of Positivist Science

Kitwood (1990) argues that the form and usefulness of a theory in practice are sometimes more crucial issues than whether the theory can be rigorously tested and seen to meet the criterion of genuine science. He considers that the prevailing style of research in social and

natural sciences - the ideal towards which investigations commonly aspire - is one in which 'variables' are isolated and causal relationships explored, through experiment or naturalistic observation. He argues that some serious difficulties with this approach have not been sufficiently recognised. Parsons acknowledged that in research with people the 'variables' are usually multitudinous, and interrelated in complex ways. Kitwood argues that the tendency of much research is to focus on those variables that can be easily measured and to ignore the rest. This can set serious limitations to conventional research.

Kitwood proposes an alternative approach, which is for researchers to be more like engineers than laboratory scientists. He compares and contrasts these different approaches. The latter seek to obtain 'noise free' knowledge in settings that are 'pure' (Kitwood 1990:194). However, engineers are involved principally with 'the performance of complex structures in real-world settings,' and so they aim to find 'predictable patterns, using materials in their complexity, and in contexts close to those of everyday use' (1990: 179).

Kitwood argues that while the results of the engineer's approach are less precise than those of pure science, they are more comprehensive and they have a direct bearing on practicalities. By staying close to the 'real context of everyday life' theory can be developed that is richly grounded in the data of real life (1990:179). So, for example, Kitwood argues that if engineers are called in to explain why a particular structure has failed, they would investigate not just the structure itself but a whole range of 'situation specific and conjunctural factors' to approximate a full explanation of why it failed (1990:194). In doing so the engineer refers both to some general principles and any unique features of the structure and setting. In this way the final form of explanation is dialectical. Kitwood argues that the points that apply in engineering - in explaining inanimate structures - do so with much more force in explaining the behaviour of

people. Furthermore, the complexity of people is many orders of magnitude greater than that of inanimate structures. A dialectical approach can provide explanations for human phenomena that involve, and are at ease with, contradictory rather than mutually reinforcing tendencies. Thus, Kitwood argues a dialectical account can get nearer to the truth.

Thompson (2000) has also argued that positivist scientific approaches have limited the development of knowledge in human services. His work, and that of Kitwood (1990), demonstrate how utilising alternative approaches to research in social work, can help overcome this limitation. Because of the significance of these matters for social work potential, this subject is developed further in the next chapter.

The following discussion explores how these matters, which Parsons (1968) considered placed limitations on further professionalisation in social work, can affect recognition of the knowledge, skills and expertise necessary for effective social work. The discussion explores the relevance of recognition, and examines some actions taken by social work to gain it. This discussion also prompts consideration of some other perspectives on professionalism.

The Social Work Strategy and Struggle for Professional Recognition

During the nineteenth century the number of professional associations established increased rapidly. In Britain, between 1825-1880, ten professional associations were established, including those for doctors, nurses, dentists and teachers (Millerson 1964). These associations concentrated upon the need to create a market for their services, and to gain status and respectability for their members. They went about this by using organisational devices that reflected both the traditional social order and the new order arising from the evolution of industrial capitalism towards its corporate form at the end of the nineteenth century (Jones 1979).

During this period the Charity Organisation Society (COS) was created (in 1869). The COS did not initially constitute a professional association for social workers. However, in the USA a professional organisation had been established for social work by 1874 (Wilensky 1964).

As discussed above, a crucial aspect in the development of the modern professions was the introduction of a system of formal education (Parsons 1968). For the newer professions this system included basic pre-professional instruction and practical training for which students could be certificated. In keeping with this, at the turn of the twentieth century, the COS formed social work lecture committees in partnership with several universities across the UK, and in 1903 they established the London School of Economics (LSE).

Jones (1979) argues that these initiatives were as much about the regulation and monopolisation of social work, and about increasing its professional credibility and profile, as they were about preparing students for practice. He suggests that social work education was used by the COS as a strategy to enhance the image of social work and 'to forge a professional and expert identity for social work and to demarcate and claim a slice of social welfare activity for itself' (1979:73).

In this way the COS used the LSE as a platform from which to seek influence over social reform policies and to promote the practical contributions that their members could make to the resolution of some of the most pressing social problems of the day (Mowat 1961). For example, the COS warned that the philanthropy of the aristocracy and the bourgeoisie had led to indiscriminate almsgiving. They argued that this situation should be addressed because it encouraged the 'undeserving poor' who preferred to survive on charity rather than search for work. The COS insisted that dealing with this dilemma required workers with considerable skill and knowledge, which could only be acquired through specific training. The COS argued that

just as doctors tended to the ailments of the body, social workers should be viewed as ‘social practitioners to the ills of society’; and they asserted that in order to fulfil this role social workers needed a methodical education, certification and registration.

Meanwhile, the COS employed other methods of gaining recognition for their work and status for the emerging social work profession. They ensured that their views and contributions were published widely in the press and they produced a monthly journal. They promoted the perspective that social policy and programmes for intervention should be based on scientific principles and that subsequent actions require the application of ability and expertise. Jones (1979) argues that these strategies illustrated how social work leaders were adept at borrowing the jargon and concepts of the more established professions in their efforts to gain recognition as a profession.

However, Jones observes that social work: ‘has had an extremely arduous time in establishing itself and gaining recognition as a discrete and ‘expert’ activity’ (1979:72). The reasons for this are many and complex, but certain factors have been identified as having an impact on social work attempts to achieve such recognition and thereby also to professionalise.

Difficulties Convincing Others of Social Work Professionalism

The difficulties affecting social workers’ endeavours to convince others of their professionalism fall into three areas: establishing a separate and distinct knowledge base; identifying definite methods of intervention and associated skills, which can be pronounced as discrete and expert; and providing evidence of the need for formal training (Butrym 1976; Payne 1996; Thompson 2000).

Parsons' (1968) argument, mentioned above, was that social workers faced serious limitations upon the extension of professionalisation because the uncertainties of changing situations in complex environments made it difficult for them to apply theoretical knowledge. He argued that social workers could not apply definite rules in such circumstances, but needed to 'play it by ear'. However, others have since argued that playing it by ear actually requires practitioners to combine theoretical knowledge (derived from a broad range of disciplines) with practice experience in order to reach judgements about the best course of action to take in highly complicated and often risk-laden situations. Hence, they argue, it is just because of the lack of definite rules upon which to rely, combined with the need for social workers to acquire an extensive range of knowledge and skills for assessing and judging the best method of intervention, that the rationale is provided for formal and advanced training, and for the recognition of expertise (CCETSW 1975; Butrym 1976; Payne 1996).

Despite this rationale, social work has had limited success in convincing others about these matters. This may be because, regardless of their efforts at claiming status for their work, others simply do not believe that social work really requires expertise. They might be further persuaded that this is the case by evidence of social work weaknesses and failures. These expose a disparity between the rhetoric concerning their expertise and the reality of their performance. Some insight concerning these matters can be found in the more critical views about professionalism, which have been adopted by sociologists who perceive limitations in the functionalist perspective described above.

Alternative Perspective on Professionalism

Since the 1970's, some sociologists have argued that the defining elements of professionalism are arbitrarily constructed and analytically ambiguous. They consider that the functionalist approach too closely reflects professionals' own attempts to portray an ideal image of themselves, while their claims to expertise, altruism and ethical behaviour are uncritically accepted (Friedson 1970; Johnson 1972; Wilding 1982).

These radical and critical sociologists have analysed professions in relation to their positions in the labour market, and to the power they hold in defining and controlling their work. From this perspective, professionalisation is seen as a process by which occupations seek to secure control of their particular market. Thus, it has been argued that self interest lies behind efforts to professionalise. Indeed, Butrym (1976) commented that among these radical sociologists the terms profession and professional became 'virtually terms of abuse', because they were seen to imply self interest and an adherence to dominant ideologies rather than expertise genuinely put to the service of others.

Among these sociologists, Friedson (1970) argued that expertise, altruism and ethical behaviour are not essential traits of professionalism, but merely aspects of 'a well rooted mythology of professionalism', where claims to such attributes are an important aspect in the process of professionalisation. Friedson purports that such claims illustrate the tactics employed by occupations in seeking to gain authority and recognition from others, and, most importantly, in looking for special privileges from the state, such as a protected market position.

In these respects, social workers have been accused of making notable use of the tactic of 'persuasive rhetoric' in order to convince others of their expertise. Wilding (1982) points to use of such rhetoric in social work's argument that practitioners require lengthy training and

education to gain an essential intellectual knowledge base. Similarly, Waddington (1996) cites Abbott's (1991) suggestion that this may be seen as social work seeking to gain jurisdiction over their particular area of work by promoting a view of their knowledge base as 'more or less abstract, esoteric and intellectual'.

During the 1960s and 1970s, the successful performance by social workers in convincing others of their expertise was particularly notable in influencing policy making. Wilding (1982) identified that social work had a significant influence on legislation such as the Children and Young Persons Act 1969, and the Local Authority Social Services Act 1970. He argued that:

The two controversial White Papers - 'The Child, the Family and the Young Offender' (1965) and 'Children in Trouble' (1968) show the triumph of social work definitions of the problems of delinquency. The assumption writ large in the White Papers is that social workers are the experts on these issues; they know the answers, and therefore the decision about the nature of the 'treatment' required is one for them - the experts, rather than for lay magistrates (1982:22).

However, Wilding (1982) was critical of social work performance. He observed that although there was plenty of evidence of their power and influence in policy making and administration, it was less easy to pick out the significance of that power for the development of services. He argued that social work efforts to persuade policy makers of their expertise were often designed to serve professional rather than public interests. Wilding's contention is that this leads to services being organised according to professional skills and ideas, rather than being designed to suit client needs.

There is, however, more to it than this. Wilding did not draw any distinctions when making his judgements between those social workers claiming expertise, those seeking to influence policy, for whatever reason, and those practising social workers and managers at the front line of service provision. Neither did he mention that weaknesses in practice may arise

because of the lack of resources available to adequately support social work, which may not be in their power to resolve. Furthermore, those who consider that it is not incompatible for social workers to seek recognition and fair rewards for their commitment and expertise even if they sometimes fail to meet expectations have presented an alternative perspective to Wilding's.

Fair Rewards for Professionalism in Social Work

Butrym (1976) argued that it is necessary for social workers to have a commitment to professionalism and for them to be recognised as a profession, because they are called upon by society to exercise expert judgement in complex and risky situations. However, when a skilled service is supplied by the social worker in response to society's needs, social rights and obligations are entailed. Amongst these is the social worker's obligation to contribute 'a serious and responsible commitment to providing a regular service in response to expectations' for which in return they have a right to receive fair payment (Butrym 1976:118).

Thus, in the process of professionalisation - or more precisely 'the process of socialisation into professionalism' - the development of this commitment is very important because it aims to ensure that social workers develop a 'professional spirit': a commitment to professionalism which primarily involves 'giving of one's best' in helping to meet the needs of the service recipients.

Butrym (1976) argues that there are four components within this process, which have been highlighted by Merton (1960) and Carr-Saunders (1928). Merton's threefold composite of social values shape the concept of a profession as:

First, the value placed upon systematic knowledge and the intellect: knowing. Second, the value placed upon technical skill and trained capacity: doing. And third, the value placed upon putting this conjoint knowledge and skill to work in the service of others: helping (1960:117).

To this is added Carr-Saunders' condition that the practitioner for supplying a skilled service receives a definite fee or salary.

Thus, while the service orientation of social work is an essential condition of social work professionalism, it does not preclude self-interest in terms of remuneration, conditions of service, promotion, etc., as long as these are not pursued at the expense of the interests of the client.

Autonomy and Self-regulation: the ultimate criteria

Other commentators have observed that weaknesses in social work performance are often associated with matters that lie outside of practitioners' control. These include inadequate training, insufficient resources, inappropriate structures for service delivery and unrealistic expectations (Warnock 1978; Barclay 1982; Browne 1982; Middleton 1996). This argument highlights how those agents who form expectations of social work - government and management - also have crucial roles to play in ensuring that social workers can, in giving of their best, also fulfil their potential.

While social workers may do their best to develop expertise and to maintain a commitment to clients, their performance may not always meet with expectations - and their ability to address practice weaknesses may be restricted by organisational or bureaucratic constraints. This apparent lack of control that social workers have over key aspects of their practice demonstrates the distinctively high amount of external control and regulation of social work, which leaves practitioners with a relatively low level of autonomy.

Among the radical sociologists, Johnson (1972) has argued that the term profession should really be reserved for those occupations that have a high degree of self-regulation and

freedom from external control. In examining the relationship between practitioners and their clients across a range of occupations, Johnson observed that some occupations that had traditionally been referred to as professions were in fact subjected to significant forms of social control. For example, practitioners controlled by powerful clients, or the relationship between practitioners and clients being mediated by a third party, such as the state or the church. Independence from such controls is seen to provide professions with the freedom to develop their working practices without restriction, to give power to command the resources they require, and to permit them liberty to address difficulties without intervention or imposition from others.

However, the significance of this occupational feature in professionalism has been challenged, particularly when it has been used to compare professionalism between traditional occupations, such as medicine and law, with newer occupations such as social work, nursing and teaching. It is argued that the degree of self-regulation and autonomy held by different professions is not static, and that all professions face some forms of regulation and accountability (Butrym 1976; Payne 1996).

However, Johnson's perspective is helpful in highlighting the significance of the relatively low levels of autonomy possessed by the social work profession and by individual practitioners. There has been significant mediation and regulation of the profession by government; and the relationship between practitioners and clients has been, and continues to be, substantially controlled by management. The management of social work is influenced by corporate and political issues of relevance to local and central government, rather than by professional issues of relevance to social work. Social work autonomy is further restricted because practitioners' authority is not independent of managerial control, and because they are required to perform bureaucratic functions associated with the needs of the organisation.

It is because of this lack of autonomy and self-regulation that social work has been classified as a 'semi-profession': a term which denotes occupations that have limitations by their nature which make it impossible for them to acquire all the characteristics of professionalism (Etzioni 1969).

The Protection of Social Work Interests: Bureau-professionalism

However, it has been argued that despite the mediation of government, significant aspects of self-regulation and autonomy have been successfully pursued by social work. Parry and Parry (1979), for example, highlight the significant influence that social work had on the movement towards 'integrated managerial structures' in state welfare services that developed in the post-war period. Managerial integration was grasped by the 'social work elite' as an opportunity to reduce functional divisions among the various social work occupations that existed at the time (psychiatric social workers; almoners; medical social workers; social work teachers; probation officers; and children's officers), because these divisions were viewed as counterproductive to further influence and professionalisation.

Management integration offered professional unification, under the umbrella of a professional association, which could control the process of recruitment, course entry and qualification. Thus, while autonomous professionalism was never a serious possibility for social workers because of the drive towards state managerialism, (and because of limited market opportunities), what ultimately emerged was a hybrid form of organisation known as 'bureau-professionalism' (Parry and Parry 1979). This term denotes a blending of the elements of autonomous-professionalism and bureaucratic organisation. The new Social Services Departments, which arose from the Seebohm recommendations (1968), provide an example of

this merging of elements within a mode of organisation that was also adopted by other government departments, notably health and education.

Hence bureau-professionalism, as it has developed since the 1970s, has provided social work with the opportunity to create a unified profession, within a 'humanised' bureaucratic structure, that is, one that offers fair conditions and rewards for employees working in the service of others. Furthermore, it has allowed the social work elite to hold positions of definite, although limited, professional control, which they have extended to incorporate other unqualified social workers in local authority employment (such as those in residential and day care services), particularly through professional training (Parry and Parry 1979).

Similarly, others have argued that despite the external regulation and control by government, social work holds substantial autonomy by virtue of management, supervision and education being provided predominantly by social workers (Friedson 1986; Payne 1996).

Friedson (1986) notes that power is shared across the bureaucracy by social workers in different positions holding different kinds of power over specific issues: the social workers over practice, the managers over resources, and the tutors and trainers over knowledge.

Who Holds the Most Power?

This idea of power sharing could suggest that practitioners, managers and educators reach agreement concerning the spheres under their control, and the autonomy they hold within these different spheres. However, since the 1980s, increasing concern has been expressed about the negative impact that management control is seen to have on social work practice. These concerns relate to how practice may be dominated by political and managerial considerations, which decide priorities, organisational structures and resource allocations, without due

consideration being given to the opinions and needs of practitioners and their clients. This domination, and the limitations it can impose on practice, can lead workers to feel restricted and alienated, and it can sometimes cause considerable conflict between managers and practitioners (Hornby 1993; Payne 1996). The dominance of management, therefore, leads to a reduction in the practitioners' span of control and influence.

Increasing concern has also been expressed, since the 1970s, about the adequacy of social work training. Public enquiries and research in both the fields of disability and children's services have revealed that social workers are ill-equipped with the necessary knowledge and skills for working with disabled children and families in collaboration with other professions (Browne 1982; CCETSW 1987)

These matters are highly significant in this thesis concerning the fulfilment of social work potential. Practitioners who feel alienated and/or restricted by their employers, who have limited control and influence over practice (including resource decisions), who are in conflict with their managers, and who feel ill-equipped for practice, would find it impossible for such matters not to affect their practice. Furthermore, such a limiting and unsatisfactory working environment can affect the efficiency with which practitioners can co-ordinate care plans and access resources for their clients (Hornby 1993).

Conversely, it has been observed that if agencies provide practitioners with employment structures that offer mechanisms for influencing decision-making and opportunities for participation with clients in service development, these can lead social workers to feel fulfilled in their work and committed to their profession and agency - and hence they do not necessarily feel alienated by managerialism (Hornby 1993).

Commitment to Professionalism: the Key to Unlocking Potential

These issues demonstrate that the fulfilment and recognition of social work potential in practice and collaboration require practitioners and agencies to commit themselves to professionalism in the service of disabled children and families. It is useful therefore to consider what commitment means and how it might be expected to affect practice. The following understanding of commitment is informed by Loxley's (1997) theory of collaboration and Butrym's (1976) theory of professionalism.

For the purposes of this debate, commitment, and how you know it when you see it, is all about attitude. An attitude of commitment is one in which the practitioner or agency aims to ensure that they can be trusted, and that others can predict the quality of their actions, so that they can have confidence in them and rely on them. Others can entrust responsibilities to those who they perceive to be committed - they are confident in the knowledge that they can rely on individuals and agencies who will understand what is required to perform the responsibilities. They are convinced. In order to maintain this trust, commitment requires individuals and agencies to understand the purposes and goals of the responsibilities and to fulfil them to the best of their abilities. An attitude of commitment also entails a willingness - more than an obligation - to do whatever it takes to achieve the goals towards which the responsibilities are directed. This includes going the extra mile to achieve them: dedication. It also includes standing up for what they believe to be right: challenging others where necessary to ensure that goals are achieved, even if this restricts their freedom to do other things and if it leads to adverse consequences for themselves.

A commitment to professionalism, and achieving professionalism, entails convincing others that they can entrust you, or are willing to see you entrusted, with responsibility for

situations characterised by risk and complexity. One of the fruits of commitment to professionalism is recognition or 'status'.

The issues explored in this chapter thus far demonstrate the importance of practitioners being committed to competence, if not expertise, in practice, and thus also to their continuous professional development. Likewise, it is important that managers are committed to supporting high standards and the improvement of services; that educators are committed to equipping social workers with the knowledge, skills and values required for practice; and that government is committed to providing adequate resources and to being realistic about what social work can achieve with the resources available.

The following discussion gives further consideration to the particular importance of commitment to professionalism for practitioners in their work with disabled children. The discussion explores the importance of autonomy and authority, the need for allegiance to clients, and the requirement of expertise in collaborative care.

Autonomy and Authority

Hornby (1993) argues that 'authority is an important constituent of professional identity.' Authority stems in part from practitioners' power in obtaining access to specific methods of help and in part from the power of their organisation. Because of the implications for effective intervention and efficient access to services, the extent to which social workers are able to make decisions and influence their managers to obtain services is likely to affect how other professionals perceive their competence and professionalism.

Social workers' authority and autonomy vary across agencies, in type and extent. Decision-making may be direct, if practitioners have devolved authority to allocate resources, or



indirect, if allocation is dependent on them influencing others who control the resources. The latter requires the worker to use their assessment to convince resource managers of need and their skills in negotiation to lever resources. To command authority, social workers need to demonstrate efficiency and effectiveness in practice. To some extent their abilities in this depend on efficient management arrangements being in place. Without a supportive organisational culture, helpful management arrangements, and adequate resources, the social worker's performance may be restricted and viewed negatively by others, and this may be regardless of any skills they might have in disability, for instance, or collaborative working. Conversely, even where the elements controlled by their agency are helpful, if practitioners do not possess the necessary knowledge, skills and values for undertaking work with disabled children and for interprofessional collaboration, they are unlikely to command authority and to make a positive impact on others.

This suggests that for potential to be fulfilled, and for collaborative difficulties at the personal level to be overcome, social workers require the following: expertise relevant to social work with disabled children and families; skills in collaborative working; and a level of devolved authority (to agree actions and resources in care planning). If social workers have these attributes, they may gain recognition from others. This can have a positive impact on their sense of professional identity - and it can also impact on the reputation of the agency.

Because autonomy and authority vary between professions and agencies, it is important that other professionals understand the level of authority that a social worker's assessment carries, and the parameters of their autonomy to agree actions and resources. If these matters are not clear, other professionals may perceive any unsuccessful proposals for intervention or services by social workers as indicating serious limitations in their skills and professionalism.

This may cause negative consequences that can lower the self-esteem of social workers and their interest in the work.

The Negative Self-image and Stereotype of Social Work

However, limitations in skills and professionalism may indeed characterise social work within any given locality; and other professionals might generalise their experiences of such limitations to social work more widely. They may form a poor opinion or negative stereotype of social workers as ineffective and lacking authority and influence (Pritchard 1978; Coulshed 1991).

Hornby (1993) has found that stereotypical views about social work predominate in collaborative settings. She argues that any 'bad stereotype' is likely to hinder collaborative relationships. Moreover, she considers that to perform well in collaborative work social workers need to feel a sense of satisfaction with their self-image. Where negative stereotypes are evident they can impede 'individualised' working relationships between practitioners, these being relationships that are based upon the practitioners' direct knowledge and experience of one another.

Although writing critically about American social work in the 1970s, Richan and Mendelsohn (1973) portrayed how the lack of autonomy and authority carried by social workers has a substantial affect on their self-image and on how others perceive them. The social worker's dependence on managers for decision making and resource allocation is described as a 'supervision strait-jacket'. An 'indigenous chain of command' and a 'hierarchy of forces' is seen to determine policy and services within social work agencies, into which individual workers are socialised. Upon entering the agency newly-qualified social workers are supervised, and this

supervision continues throughout their careers regardless of their expanding knowledge and experience, and despite their eventual position in the chain of command. Richan and Mendelsohn (1973) consider that no other profession imposes so much supervision as does social work.

Arguably, there are some cogent reasons for the extent of this supervision. No matter how experienced a social worker may be there are good professional reasons for continuing with supervision, mainly because of the worker's use of self in providing help or therapy for their clients. Furthermore, there may good management reasons for supervision, such as the imperative to deal with risk and legal requirements, and the need to identify clear work objectives and the worker's training needs. However, Richan and Mendelsohn argue that practitioners can experience the extent and nature of supervision as an imposition, which has an effect on their sense of professionalism.

There is an important side effect for the ego of the social worker. He may at some time ask himself at what point he stands on his own two feet. At what point is he a professional capable of making his own decisions? (1973:98).

Hence supervision is viewed as having become a condition of professional life for social workers, which has cast them into a 'career of dependence'. Another side effect is that others may ask themselves whether it is worth investing time and effort with social workers if decisions cannot be made without reference to their managers.

Barclay (1982) reported a concern about social workers in this vein after consulting a group of parents of disabled children who considered that 'They can't seem to cope with your needs but pass you on... they can't make decisions without ringing another department first...' (1982:168).

Richan and Mendelsohn (1973) also portray social worker's use of case conferences as an illustration of their indecision and dependence. They argue that social workers rarely plan or undertake action without the agreement of a large number of people:

The implicit reassurance is that should the plan fail, there is enough shared responsibility so that the guilt will not be borne solely by any one individual (1973:99).

It is certainly not conducive to good interprofessional relationships if this is how social workers use case conferences. Furthermore, if this is how others perceive social workers' consulting with them over important decisions, it is certain to affect badly their willingness to collaborate, which in turn will affect the social worker's ability to fulfil their role. Ultimately such matters will have consequences for the social workers' self esteem and enthusiasm for the work.

The discussion of collaborative working in Chapter 2 suggests that to counteract these sorts of negative perceptions, and to overcome collaborative difficulties, social workers would need to explain why they refer some decisions to others and why they consult through case conferences. They would need also to make clear their own contribution to the decision making process. The findings of discussions in this chapter suggest that they need also to explain for others the boundaries of their decision-making authority and the criteria for accessing services from their organisation. Ultimately, if social workers are to address perceived or actual limitations in their abilities they may need to negotiate with their agency over the parameters of their autonomy to ensure that it allows for efficiency of decision-making. Arguably, if agencies fail to develop structures, procedures and processes that support social workers in collaborative working and care for disabled children then they are failing to recognise and value the potential of their own workers.

Client Commitment

Bearing in mind the understanding of commitment discussed above, it would seem that the willingness of social workers to challenge ineffective systems, within their own and other agencies, requires a strength of purpose that derives from a commitment to their clients. Social workers may demonstrate their commitment to professionalism through their understanding of the issues affecting their client, and through their willingness to use whatever power and influence they have to improve practice. However, some commentators have expressed serious concerns about the lack of commitment displayed by social workers to disabled children. They have stated particular concerns about the weakness of social workers' allegiance to disabled clients when other areas of work appear to offer them greater interest and rewards (Wolfensburger 1975; Parry et al. 1979; Browne 1982; Middleton 1995).

It has been argued that managerial control and the limited autonomy of social workers have sometimes pushed commitment to clients into the sidings (Browne 1982; Payne 1996). This is most evident in two situations: first, when management requires social workers to undertake work that the agency and/or government consider a priority - this also being where they target resources and employment opportunities; and second, when social workers choose this priority work because it offers them recognition and rewards. In these situations, social workers might see that undertaking management priorities can help them to fulfil their professional ambitions by providing them with such rewards as autonomy, authority, recognition, status and access to resources. These situations may be characterised by an interdependence between social workers and their agencies, in which the course taken meets the needs of both (Wolfensburger 1975; Middleton 1996).

The lack of social work allegiance to disabled people early in the twentieth century has been widely reported (Wolfensburger 1975; Parry et al. 1979; Browne 1982; Craft et al. 1985; Heddell 1988). The circumstances surrounding this are worth examining because they highlight how social workers can weaken their potential in disability work, and their reputation as committed professionals, if they neglect their responsibilities in the search for rewards elsewhere. This example is interesting also because there is evidence that the consequences of social work's actions continue to reverberate upon their practice with disabled people today.

Poor Allegiance and Lost Opportunities - the example of learning disability

Craft et al. (1985) argue that social workers failed to grasp powers and opportunities available to them in the early twentieth century, which could have led to significant improvements in the care of adults and children with learning disabilities. These opportunities arose from the Mental Deficiency Act 1913, and the enlightened ideas of the Wood Committee (1914-20). These government-led initiatives, combined with advances in psychiatry, developments in child care services, and an increased understanding of the needs of families, provided social workers with the chance to influence the course of service provision for this client group. However, Wolfensburger (1975) argues that social workers neglected the opportunity. Moreover, Craft et al. (1985) observe that as a consequence the social work role with these clients remained largely static for half a century, from when the 1913 Act was introduced until the 1960s.

Wolfensburger (1975) argues that social work agencies neglected the development of community services despite considerable evidence of the need to move away from the oppressive institutional models of care that dominated disability services. He considers that this neglect

exemplified the lack of social work commitment to this client group. He perceives that this was partly due to 'the pessimism communicated by the workers in the field', who lacked interest in working with learning disabled people, and who were not persuaded by the need for change in their care arrangements. He considers that this neglect also arose because 'the interests of professionals became attracted to the new discoveries and increasing treatment opportunities in the area of mental health' (1975:35).

Similarly, Parry and Parry (1979) argue that social work interests were attracted to mental health and the possibilities it held to strengthen their assertion of professionalism. They cite evidence of this within social work's subsequent use of scientific psychology to develop a legitimating knowledge base to provide a theoretical basis for casework practice. However, the attention social work gave to these interests was at a cost to more pragmatic matters, including the development of services for disabled people.

It has also been argued that despite the substantial growth in social work education since the early twentieth century little importance has been accorded to training in social work with disabled children and adults. Browne (1982) asserts that the dearth of literature on the social work role reflected both 'the lack of interest amongst trained social workers in the field and the relatively little teaching about it on professional courses.' Browne (1982) argued that the combination of society's values and beliefs, and the theoretical orientation of psychiatric social work, seemed to contribute to the low priority accorded to social work with learning disabled people. The ambivalent attitudes of society towards disabled people were mirrored in the social work response to such work, and social workers colluded with other professionals in viewing institutional seclusion as an acceptable way of meeting their needs.

Child Protection: the Key to Commitment and Change

Thus, in the early twentieth century social work failed to sufficiently understand and address the needs of families with disabled children. In the latter part of the twentieth century, and at the turn of the twenty first, there has been criticism of the continuing lack of investment in disability work and the low priority accorded to disabled children and families within social work (Browne 1982; Gilbert 1985; Heddell 1988; Middleton 1996; Rickford 2000).

Gilbert (1985) found that work with intellectually disabled people and their families was a low priority for many local authorities. The services families received often amounted to little more than a simple review undertaken by an unqualified worker, rather than a careful monitoring of needs over a longer period of time by designated and skilled practitioners. Gilbert noted how these findings contrasted sharply with the 1971 White Paper view of the social worker as a long-term co-ordinator.

Similarly, as discussed in the previous chapter, when the Children Act 1989 was introduced, BASW (1992c) expressed grave concern that the priority given to other aspects of children work would continue to overshadow the real needs of disabled children. The realisation and justification for these concerns have been reported more recently (Middleton 1996; Rickford 2000; Wonnacott and Kennedy 2001; Hooper 2001). These writers show how despite the opportunities offered by the Children Act there is continuing evidence of social work failures to meet the needs of disabled children across the UK. For example, in commenting on the opportunities for improving practice offered by the new 'Framework for the Assessment of Children in Need and their Families' (NAFW 2001), Wonnacott and Kennedy (2001) draw attention to the continuing existence of institutional discrimination towards disabled children within the field of child welfare. Rickford (2000) writes about 'the forgotten families' and

observes that many families caring for severely disabled children are still not receiving the help they need and that only one family in three with a disabled child has a key worker. Rickford's research revealed that adequate information for families about the services available to support them is still provided on a 'hit and miss' basis and, although there are some very good services around, they are patchy. Rickford notes that receiving an assessment and fulfilling the local authority's eligibility criteria seems less of a problem for disabled children and families than the shortage of services to meet their assessed need. However, Hooper (2001), a trainee social worker, caring for a son with Asperger's syndrome, writes about her own experiences of seeking help from social services and observes that despite three requests for an assessment of need her family were told that they did not meet the eligibility criteria because her son was not 'a child protection case'. Nobody visited to discuss their situation before reaching this conclusion, and yet they were facing considerable stress from their son's hyperactivity and obsessional behaviour. Hooper states that it felt to her family 'like another judgement from a society that doesn't understand or care.'

While most of these writers direct their concerns at agencies, Middleton (1996) argues that self-interest and ignorance on the part of social workers also plays a significant part in the failure of agencies to fulfil their responsibilities to disabled children. She argues that what amounts to a collusion of ignorance and self-interest has led to substantial investment being made into child protection work while children's disability services continue to be neglected.

Meanwhile, other commentators have observed the extra pressures added to social workers' workload because of the increase in reported cases of child abuse. However, they do not consider that this provides social workers with a reason for putting their work with disabled

children into second place. On the contrary, because disabled children are found to be more vulnerable to abuse than other children, it has been argued that:

It is important for the social worker to monitor carefully those families with particular problems, such as a child with behavioural difficulties, because the stresses and frustrations can easily lead to a risk of abuse (Heddell 1988:156).

From arguments such as these it may be seen that the key to change in professional and agency commitment to disabled children might rest within child protection work.

Research undertaken by Bone and Meltzer (1989) and Kennedy (1996), reveals the higher incidence of child abuse of all kinds among disabled children. However, disabled children are largely invisible in mainstream child protection (Middleton 1996). Concerns have been expressed that reports of the suspected abuse of disabled children are not taken seriously because the current system discriminates against these children at all levels of the organisation (Wonnacott and Kennedy 2001).

Middleton (1996) argues that if social work agencies and practitioners were to take seriously these research findings, then their focus should fall upon how disabled children are to be protected. These enquiries would then, by definition, lead to other crucial issues being addressed, such as the rights of disabled children, equality of opportunity, the organisation of services, and the rights and responsibilities of parents. Thus, services for disabled children would complement and integrate with child protection services, rather than be seen as a separate obligation or alternative issue.

The immense government and media attention given to child protection, and the serious implications of adverse publicity and public shame if reports of abuse are not expertly investigated, lead social workers and local authorities towards a mutual interest in ensuring that

child protection work is done well. The consequences of this are discussed in the light of the survey findings in Chapter 9.

The Real Challenge: Combating Discrimination

There are reasons why disability work can be unattractive to social workers, some of which may be due to misunderstanding about the tasks involved, which will not be discussed here, and others which are real enough and can make the work particularly demanding. These reasons include the lower status accorded to disability work within social work agencies, which arises from the lack of acknowledgement of the value of such work. It is also a reflection of the low status of disabled people in society, which is perpetuated through institutional discrimination against disabled people in welfare agencies. This discrimination exposes inconsistencies in the application of social work values, use of the social model of disability, anti-discriminatory practice, and in child protection work (Middleton 1996; Wonnacott and Kennedy 2001).

It was noted in Chapter 3, that those social workers who choose to work with disabled clients often describe an experience of being on the outside of mainstream social work (Middleton 1996). Such feelings of isolation and alienation may be further aggravated if the social worker is based in a working environment where other professionals perceive difficulties for disabled children and families to stem from the child's impairment rather than from disabling barriers, discrimination, oppression and exclusion. Where the medical model dominates, other professionals' expectations of social workers may reflect a treatment and problem-solving perspective and thereby create a significant challenge for them to orientate the child's plan using a social model. The sources explored in this chapter suggest, however, that if social workers are to be consistent in their values and commitment to protecting all children from abuse, then they

would perceive it as their responsibility to contribute to the welfare of disabled children, and to take up the challenge of combating discrimination. Moreover, they might also expect a similar commitment from their agencies, with similar resource investment as they give to child protection work, such as the provision of skilled workers and training, and the management support given to interagency and interprofessional collaboration.

The Importance of Expertise in Social Work Professionalism

This chapter has identified tensions in the debate concerning social work claims to expertise. These tensions suggest that it is important to ascertain what expertise means and whether it really is required and used in social work practice.

Within the functionalist perspective examined above, it is perceived that professionals require formal training because the knowledge and skills that they need for practice are intellectually demanding. The knowledge is demanding in its complexity, as is the application of this knowledge in the practice of technical skills. The achievement of proficiency in using the knowledge and skills for competent practice requires training institutions to test and confirm students' ability. The concept of expertise implies the development of more advanced knowledge and skills than those required for competent practice. Expertise suggests that the practitioner has developed such a level of proficiency that their judgement about the course of action to take has authority and can be trusted to provide the most effective outcome; and that the outcome would be better than if there was no professional intervention. Do social workers require such expertise for work with disabled children and families?

It was established in the earlier discussions in this chapter, that the radical sociologists and critics of the functionalist perspective argued that social work's claim that their practitioners

require formal training to prepare them for intellectually demanding work is just an attempt to convince others that they have expertise. While the critics accuse social work of exaggerating the issue for reasons of self-interest, they did not disagree that social workers require expertise for practice. The evidence from the discussions in the thesis thus far is that expertise is required for social work with disabled children. There is also evidence that a less than expert approach leads to strong criticisms of social work (Payne 1996). By contrast, there is also evidence in examples where others have praised social workers for practice that demonstrates a level of understanding and insight that comes from expertise.

The Expectation of Expertise

Criticism and praise give an indication about the standards of service expected from social work. Butrym (1976) reports that generally clients expect and require 'efficiency, reliability and expertise' from social workers. She argues that the public expect social work to be carried out effectively and with clear purpose, and that 'society has a right to the assurance that its expectations incorporated in the mandate given to a profession are in fact fulfilled (1976:118). Fulfilling these expectations meets with approval, while failure is strongly criticised. Payne (1996) argues that this is rightly so, because professionalism in social work implies more than claims to expertise, it implies 'a basis which allows the occupation moral approval if it is done well' (1996:143).

The sort of criticisms that have been made of social work in children's disability services include: the allocation of work to unqualified, inexperienced and immature staff; a lack of knowledge about the range of services available; inability to make decisions about actions and resources; ignorance concerning the needs of disabled children and other family members; poor

communication skills with children; and the failure of workers to address complex and serious issues, including child abuse (Threlfall 1979; Barclay 1982; Browne 1982; Heddell 1988; Middleton 1996; Rickford 2000). These criticisms demonstrate that clients expect social workers to be experienced in the needs of disabled children and families and to be equipped with a broad scope of knowledge and skills.

This thesis argues that social workers have the potential to meet these expectations and to provide expertise. However, it seems that to fulfil their potential social workers need opportunities to develop proficiency and judgement through combining practice experience with the knowledge and skills that they acquire in training. Butrym (1976) argues that through reflective thinking social workers are able to develop 'practice wisdom'. This enables them to use the synthesis of their knowledge, skills, values and experiences to reach informed and reliable judgements concerning intervention. Similarly, Payne (1996) argues that social workers gain unique experiences and insights because they must intervene in complex and uncertain situations where other professionals would not be required to go. Payne considers that reflection on these insights enables social workers to develop understanding and to hone their skills in judgement.

However, there are warnings that social workers themselves can fail to recognise the need for their particular skills in some areas of work. Rose (1992), for example, argued that the employment of unqualified workers as care managers in some authorities demonstrates how managers can consider that the task of co-ordinating care plans does not require the skills of qualified social workers. Rose considers this an example of social workers failing to convince management and government that these tasks do require their expert knowledge and skills. However, he suggests that social workers may not have sought to convince others of this because

they agree that such tasks do not require their knowledge and skills, which they believe should be reserved for even more expert tasks, such as treatment, therapy, and the management of high risk casework. Rose maintains that for the preservation of professional status it is essential that social work averts an erosion in the recognition of their skills by not permitting tasks that require their expertise to be downgraded.

The Necessity for Expertise in Children's Disability Services

These observations from Rose (1992) are useful in highlighting the importance of considering whether certain social services really do require qualified social workers. Many services, most notably residential and day care services, operate without qualified staff. Are criticisms of managers allocating disability field work to unqualified and less experienced staff really justified? The public's criticisms and praise suggest that they want expert workers, but does the work actually require the knowledge skills and expertise of qualified and experienced workers?

A brief review of the social work roles and responsibilities, as detailed in Chapter 3, serves to illustrate that expertise is required. Social work with disabled children entails undertaking holistic assessments of need in partnership with parents. This requires skills in assessing child development and an understanding of the effects of various disabling conditions. Social workers are required to advise, support and counsel disabled children, their parents, foster carers and other family members. Their work entails identifying useful resources from different agencies. They have responsibility for advancing important values concerning children's rights, anti-oppressive practice and the social model of disability. They are required to use judgement as to whether statutory powers of intervention should be used to protect vulnerable children.

Finally, they have responsibilities to work in collaboration with other professionals particularly in co-ordinating the child's plan.

A depth of knowledge and experience is required for most of these tasks. More than competence is needed, because social work with disabled children is rarely uncomplicated. Many situations that social workers deal with are complex and emotive and may also be characterised by crises. They may have to confront child abuse and neglect, or to counsel children and families regarding challenging behaviour. Acquiring the knowledge and skills necessary for intervention in these situations not only requires social workers to know a great deal about disability work, but also to continuously develop their knowledge and skills (their opportunities for doing this are explored in the next chapter).

The Necessity for Expertise in Collaboration

The criticisms and praises of social work indicate that other professionals also want social workers to provide expert services. These professionals experience the good and not so good performances of social workers as they go about their work with disabled children. Through their practice experience, they form opinions about the knowledge, skills, efficiency and reliability of social workers. They may consider that the professional status of social work permits them to expect that the quality of social work practice, including collaboration, should be comparable with their own and that of other professions.

If others' form their opinions about social work professionalism in child disability work through experience of unqualified, inexperienced and indecisive social workers, who fail to communicate effectively - which the sources cited above suggest to be likely - then their opinions may be highly critical. If social workers fail to meet their expectations this may affect their

willingness to co-operate with and relinquish tasks to them. Therefore, despite social work's claims to be the best-qualified profession to facilitate collaboration, others may not permit them to play a leading role in this. It is upon these matters that the field research for this study focuses, by asking health and education professionals for their views about social work.

These discussions reveal that a significant challenge faces social workers looking to fulfil their potential. Those possessing the appropriate skills to help clients such as disabled children will also need some expertise in the skills relevant to collaborative working - not just for liaison, but for taking a leading role in multidisciplinary assessment and care planning. To gain further insight about these matters, the field research for this study asks social workers if, and if so how, they have acquired these skills.

Conclusion

This chapter has argued that professionalism, characterised by expertise and commitment, is essential for social work with disabled children. In addition to the specific knowledge, skills and values necessary for working with disabled children and families, social workers appear also to need to master skills for interprofessional collaboration. The importance of social workers providing disabled children and families with expertise in collaborative care arises because of the positively helpful difference they can make in the lives of these children and families - in ways distinctive to social work - and because of their particular responsibility for combating discrimination. However, the evidence in this chapter highlights the particular importance of social work training if social workers are to develop the knowledge, skills and values that they need for competent and expert practice. This chapter has identified that to fulfil their roles in collaborative care, social workers need to acquire and maintain a breadth and depth of

knowledge. They need to learn how to blend this knowledge with practice skills, values and experience in order to provide an expert service. They need also to be confident in their decision-making and professional judgement if they are to provide consistently efficient and effective services. Because of the significance of these matters, the next chapter explores the training opportunities available for social workers and how these prepare them for practice with disabled children and in collaborative working.

Although this chapter has demonstrated reasons why social work's ability to achieve higher professional status might be limited, the argument is that a discernible improvement in their practice could provide social workers with an improved reputation and self-esteem. Good practice examples, where social work interventions have made a significant impact for clients, can illustrate the potential of what can be achieved if successful schemes are extended through investment, or if resources are redistributed in favour of a quality social work service for disabled children.

However, social workers can perform poorly in child disability work and collaborative care. The discussions in this chapter have highlighted how, just as there are advantages in addressing collaborative working at interpersonal, interprofessional and interagency levels, likewise social work potential might only be fulfilled if action is taken at personal, professional and agency levels. Regardless of the expertise of individual workers, their success is inescapably linked with the relationship they have with their agencies. Social workers depend upon their agencies to provide training opportunities, suitably qualified and experienced staff, and a range of support services to meet clients' needs. They depend upon management to establish organisational structures, procedures and processes that allow them to practice in the most

effective way - this includes maximising opportunities to devolve responsibility for decision-making, so that social workers can practise autonomously where necessary.

Chapter 5

Social Work Education and Training

Introduction: training for new roles

This chapter explores another key aspect of professionalism and social work potential: the content and quality of social work education and training. This discussion is important because, as revealed in Chapter 3, the social work role with disabled children requires a wide range of knowledge and some ‘specialist’ skills. Furthermore, as concluded in Chapter 6, criticisms of social work practice with disabled children demonstrate that other professionals expect appropriate skills, if not some expertise, from social workers involved in this field of work. The object of this chapter is, therefore, to explore how the training really measures up to meeting these requirements and expectations.

During the 1980s, improvements in services for disabled children were frequently attributed to interprofessional initiatives. As the discussion in Chapter 2 illustrated, working together increasingly became seen as an essential ingredient of success in developing practice. Chapter 5 identified how the Children Act 1989 and the NHS and Community Care Act 1990 built on this by stressing the value in local authorities developing services based upon collaboration and multidisciplinary working. Accordingly, there has been an increasing emphasis on the importance of training to prepare professionals for this way of working (DoH 1991c; 1998). This chapter begins by exploring the opportunities social workers have to learn about collaborative working and to develop collaborative skills through qualifying and post qualifying training.

The chapter goes on to consider how the Central Council for the Education and Training for Social Workers (CCETSW), and more recently the Training Organisation for Personal Social Services (TOPSS), have responded to concerns, arising from research and public enquiries, about the lack of even basic competence in some areas of children's services. These include weaknesses in the application of social work principles, shortcomings in effective collaboration with other professions, and a general failure to provide appropriate knowledge and skills in more specialist areas of work (DHSS 1974; Pinker 1994). The chapter explores how the training bodies have tried to meet the demands of employers and others for an improved and more consistent output of skilled practitioners from social work qualifying courses (CCETSW 1975; 1991; 1995). The chapter also explores the increasing significance given to continuing professional development (CPD) in meeting these demands (CCETSW 1995; Steele 2001; Robb 2001).

The Certificate of Qualification in Social Work (CQSW) and the Diploma in Social Work (DipSW) are viewed in some detail during these discussions because at the time of the field work for this thesis most social workers had qualified via these routes.

Finally, the chapter considers arguments that attempt to explain why, despite changes to the qualifying courses and the increasing availability of post qualifying opportunities, social work training continues to meet with criticism (Robb 2001). This includes a discussion of the part that can be played by research in enabling social workers to overcome perceived limitations to the professional status of their work. Consideration is given to the importance of social work developing more appropriate approaches to investigation and theory in social work practice.

Learning Opportunities for Interprofessional Collaboration

The following section considers the importance of professionals developing their knowledge of others' work and explores some of the opportunities available for social workers to do this.

Griffiths (1988), Barr (1993) and the UK Centre for the Advancement of Interprofessional Education (CAIPE 1993) all suggest that training and conferences, particularly jointly organised initiatives, can provide valuable opportunities for professionals to learn about each other and to generate solutions to many of the difficulties that arise in collaborative working.

Barr (1993) refers to Roy's argument that for community care to work effectively each professional has to 'stop being precious about assessment' (1993:3). Roy considers that joint training initiatives and a common core training curriculum for all care professions can assist with this. She cites evidence proving that 'people who learned together respected and valued each other' (Barr 1993:3). For similar reasons, Stevenson has argued that the exploration and understanding of each other's role should be an essential component of post-qualifying interprofessional studies (CAIPE 1993).

In preparing his report on community care, Griffiths (1988) remarked on how struck he had been by the 'insularity of training for each professional group.' While he considered that a common training in skills for everyone working in the community might be over ambitious, he nevertheless argued that 'an understanding by each profession about the role of the other professions in the community could easily be achieved.' He proposed that agencies should work together over this matter to ensure that it formed part of basic training plans at a local level. Five years later, in his presentation to the 'Working Together' Conference (1993), Griffiths reiterated this view, and reminded conference members of the White Paper (DoH 1989) assertion that 'it

will be important to continue to develop multidisciplinary training for staff in all caring professions, including the provision of joint training at both the qualifying and post-qualifying stages' (1989:8.33). Griffiths also repeated his suggestion that 'training authorities may wish to adapt existing training programmes and consider providing such training in a multidisciplinary setting in order to enhance understanding between health and social service professionals' (1989:4.18).

This emphasis upon training demonstrates the reliance on both colleges and agencies to convey important messages about the value of interprofessional collaboration, and to make available to students and employees the knowledge they require to participate in and ensure the success of collaborative initiatives. The UK Centre for the Advancement of Interprofessional Education (CAIPE) stress that the attitudes and expectations that professionals develop about each other can be significantly affected by the manner in which their learning is accomplished - and that the impressions they receive can have a lasting impact. Opportunities for learning collaborative skills have increased substantially over the past decade. Some of the forms that such opportunities can take are described below.

First, there are shared-learning experiences, such as interprofessional training seminars or college-based courses. In their survey of interprofessional training for community-based health and social care, Barr and Waterton (1996) found nearly 500 such initiatives across the UK, three quarters of which were at post-qualifying level. Second, there is participation in service planning. Levita, Jones and Heerstadt (1994) cite evidence of how the participation of all relevant professionals in the development of a new Child Development Centre for diagnosis, assessment, therapy and care management for disabled children led to the centre operating in an 'efficient, effective and highly professional way.' The researchers found that collaboration

between professionals in planning the centre increased group identity, encouraged professionals to learn from and about each other and reduced the stress-provoking factors normally associated with significant change - such as role ambiguity, role conflict and threats to existing values and norms. Third, there is attendance at conferences and workshops. Lauerman (1997) stresses the benefits of multidisciplinary conferences that focus on daily and local experiences of 'working together'. He highlights how such conferences can encourage the construction of 'conscious links' for interprofessional working at all levels of the organisations involved, and enable professionals and their agencies to create 'formal processes and structures' to enhance learning and working together. Finally, there is participation in interprofessional networks. The 'NHS Centre for Reviews and Dissemination' (1997) highlight the benefits of linking professionals together in networks to disseminate research evidence and to encourage evidence-based practice in interprofessional service developments. The University of Glasgow-based group 'Interact' demonstrate the advantages of bringing health and social care professionals together to share information through informal networks and conferences, to discuss major issues of common concern, and to map out better ways of interprofessional working in the interests of service users (Alexander 1994).

These are just a few of the opportunities for social workers to develop their skills in collaborative working and their relationships with other professionals. Others that have proved to be helpful include secondments and practice placements, observation periods in multidisciplinary teams and, of course, college lectures, seminars and assignments on collaborative working during qualifying and post-qualifying studies.

The next section considers in more detail the importance of other professionals' perceptions of the content and quality of social work training, particularly at the qualifying level,

and how these might have an impact on the effectiveness with which social workers fulfil their role.

Enhancing Credibility

The opinions that other professionals carry about social work education and training, and the accuracy of their knowledge about it, have been found to impact on their recognition of social work contributions and the approach they take to collaboration with social workers (Warnock 1978; Barclay 1982; McGrath 1992; Robb 2001). Furthermore, if other professionals do not consider social workers sufficiently and properly qualified for their work then collaborative difficulties arise (Kane 1975; George et al 1986; Hornby 1993). These difficulties, which were highlighted in Chapters 2 and 6, include impediments to referrals, unwillingness to negotiate tasks, and a range of barriers to coordination.

Considering the statutory responsibility social workers carry for disabled children, it might be anticipated that others will expect the quality of their training to be high. They might expect social workers to receive advanced training, to have been selected for the course because they demonstrate an aptitude for the work, and to have been rigorously tested by their tutors to prove their competence. (Some of these assumptions are tested out within the field research for this study.) However, there have been long-standing criticisms from other professionals about the adequacy of social work training in preparing students for practice. Despite initiatives to improve training in recent decades, continuing dissatisfaction has been expressed about the abilities of students leaving qualifying courses (Robb 2001).

There are, therefore, evident tensions in the debate about the credibility of social work training. These tensions can be seen in the following areas. Firstly, others may consider that

most weaknesses in social work practice arise because their training is inadequate. They may perceive that any lack in understanding of the needs of disabled children and families, or failings in collaboration, arise because social workers have not received appropriate training. Hence, they may think that improving training will enable social workers to improve practice and overcome practice weaknesses. However, whatever truth there may be in this perception, there are nevertheless other factors than inadequate training that cause weaknesses in practice. Some of these were identified in Chapter 5. They include agencies failing to give child disability work sufficient priority for their qualified staff, fragmented service structures, and insufficient opportunities available for social workers to gain practice experience (Browne 1982; SSIW 1991; Middleton 1996).

Secondly, some professionals may perceive that social workers require particular knowledge and skills, perhaps at the level of an expert or specialist, to fulfil their responsibilities in complex and demanding practice situations. Conversely, others' knowledge of the social work role may have led them to conclude that most social work with disabled children and families is neither complex nor demanding, and therefore that the tasks do not require professionally qualified social workers. These contrasting perceptions highlight the need for others to have accurate information available about the social work role and the knowledge and skills required to fulfil it. This links with the third area of debate, which is that some professionals might disbelieve social work claims to credible training no matter what. This may arise for several reasons. It may be because they reject outright social work's claims to have appropriate knowledge and skills for the role assigned to them, regardless of the quality of their training. This may be because they are protecting their own territory in child disability work. It may also arise because they do not perceive social work knowledge and skills to be that relevant to the

care of disabled children. They may think that other professionals have more relevant knowledge and skills than social workers. Those who think this might also consider that social work has nothing distinct to contribute, or they may not perceive that which does (or perhaps should) distinguish the social work contribution from that of other practitioners. Finally, this disbelief may arise simply because others do not accept that social work can 'cut the mustard'. The criticisms of social work training and the weaknesses in social work practice have gone on for too long. The credibility of social work and its training is scarred, and has left others carrying serious concerns about the profession's competence. Others' concerns may be reinforced by evidence that several attempts to overhaul social work training have failed to achieve much improvement: the same weaknesses are evident, the same mistakes are made.

Thus these tensions muddy the water as far as convincing others is concerned. Most of these areas of debate are not addressed in this chapter, which focuses on the content and quality of social work training. However, they are mentioned here because it is important to acknowledge the significance of these issues in collaborative working, and to highlight how some of these perceptions may underpin the responses of other professionals in the survey enquiries for this research.

Some fundamental issues about the content and quality of social work training have emerged from this discussion. Such as, that if others' opinions concerning the adequacy or otherwise of social work training are to be accurate they require information about what social work qualifying training contains and entails, and what other opportunities are available for learning. Moreover, other professionals are not likely to judge the quality of social work training by their knowledge of the syllabus; they are more likely to form opinions through their satisfaction or otherwise with the performance of social workers in front-line practice. The

following discussions therefore explore how social work has aimed to inform and convince others of the credibility of its training in preparing students for practice.

Making Standards Known

Key aspects in convincing others of the adequacy of social work training have been the need to make known the content of available courses and to show the importance that social work attaches to intellectual rigour, competence and expertise. When CCETSW was established in 1971, it was given the task of regulating and accrediting all qualifying courses. It immediately responded to the criticisms of social work training and the demands for improvements by undertaking an analysis of how competence and expertise are developed in social work. While CCETSW accepted the need to satisfy increasing demands from employers to improve students' preparation for practice, the analysis undertaken also convinced CCETSW of the importance of theory within practice. CCETSW were persuaded by the academic argument that all practice is theory-based, and that a social worker's choice of intervention method is influenced by their knowledge of alternative theoretical models and how to apply them (CCETSW 1975). Consequently, the synthesis of theoretical material with practice skills became a key objective for CCETSW in preparing guidance for a generic social work qualification.

The Importance of Social Work Theory

A brief discussion of the relevance of theory in social work is useful in revealing the important function claimed for theory in the development of competence, expertise and status, and in the fulfillment of social work potential.

Howe (1987) provides a simple description of theory as 'a set of concepts and propositions that present an organized view of phenomena.' In social work, Howe argues that the utility of theory rests in providing workers with the facility to 'summarise existing knowledge, to categorise and relate observations and to predict the occurrence of as yet unobserved events and relationships, on the basis of the explanatory principles embodied in the theory' (1987:21). Similarly, Coulshed (1991) argues that theory can provide explanations of complex human situations, so that out of chaos, patterns and regularities in behaviour and situations may be identified. Thus, if a social worker can anticipate what may happen next, and can estimate the likely effect of any particular intervention, then their use of theory can lead to an improved reliability of outcome, which will ultimately lead to a more efficient and effective service. In this vein, Butrym (1976) has argued that social workers must make use of theory if they are serious about wanting to improve the effectiveness of their interventions and the quality of services.

Applying theory in this way requires social workers to use knowledge of different theories to select those most helpful. It may also be necessary for them to use insight gained from experience, reflection and critical thinking in a systematic manner to decide on the best course of action. Examining the relationship between practice and theory, Butrym (1976) and Payne (1996) both argue that in determining the best intervention for dealing with complex human situations social workers use knowledge and skills that arise from a combination of training and practice experiences that are unique to social work.

These arguments portray the use of theory by social workers as a skilled activity. Decisions about any course of action are theoretically informed, rather than arbitrary or routine. However, there is evidence that the manner or extent to which theory is used varies between social workers.

Many writers have observed that use of some sort of theory is unavoidable in social work practice (Briar and Millar 1971; Whittaker 1974; Fischer 1978; Corby 1982; Howe 1987; Coulshed 1991; Thompson 2000). These writers argue that theoretical views and assumptions are at least implicitly present, even if there is a lack of explicit acknowledgment or recognition. Other writers argue that social workers must develop understanding about theory because, as well as informing strategies for intervention, theories implicitly hold value orientations which may profoundly affect the nature of the service that they deliver (Briar and Millar 1971; Whittaker 1974; Dominelli 1988; Thompson 1993). Indeed, the adoption of different theoretical perspectives is both due to, and can lead to, workers seeing things differently. Because of this, dilemmas can arise where individual social workers give different answers in the same situation to basic questions about what the problem is, what can be done and how to do it. Thus the relationship between social work theory and good practice is complicated. The problems seen, the assessment made, the goals set and the methods employed for achieving them, may all vary according to the theoretical position held by the social worker (although amongst the professions social workers are not unique in having varied responses to the identification of and solutions to problems). Dominelli (1988) argues that this sort of dilemma highlights the importance of social workers being explicit with others about their own and their agency's perspective and value system. Similarly, Thompson (1993) highlights the importance of social workers being able to articulate their perspectives and the rationale behind their interventions so that they can respond to others' questioning within multidisciplinary settings.

However, despite these arguments concerning the importance of theory, there is substantial evidence that social workers do not make systematic use of it and are not generally

able to articulate how their methods correspond to a theoretical model (Fischer 1978; Stevenson and Parsloe 1978; Hardiker and Barker 1981; Corby 1982; Coulshed 1991).

Fischer (1978) and Corby (1982) have reported research that showed that social workers are not sufficiently convinced of the value of underpinning their work with theory, and hence they generally do not systematically plan their interventions using an explicit theoretical basis. Corby (1982) found that although social workers were clear in describing and assessing, they were uncertain as to what they were trying to achieve. These findings present a challenge for those who seek to advance professionalism in social work. The findings suggest that although theory may be unavoidable, it is not always necessary for social workers to make considered use of it. Hence, social workers can and evidently are undertaking their work without explicit or conscious reference to it. However, those who fail to acknowledge and use theory face strong criticism. Coulshed (1991) censures those practitioners who have no method, those who cling to one preferred school of thought, those who are 'whimsical' about their choice of approach and those who dive into a 'rag-bag' of ideas. Coulshed argues that 'those who discount intellectual scrutiny and vigour undermine the credibility of our profession' (1991:2); and agencies that profess not to use theory offer a 'non-problem solving, woolly and directionless service' (1991:8). Similarly, Howe (1987) argues that the relegation of theory 'to an implicit, unarticulated status, leads to a poor, indeed dishonest practice' (1987:1).

Coulshed's work highlights a further issue that has particular relevance to this thesis. She identified that a social worker's choice of intervention is often constrained by the agency within which they operate and/or by the nature or pressure of their work. She suggests that, because of this, social workers can only be as competent and effective as the system allows them to be. Observing that social workers are essentially agents of their organisations, she considers that

social work approaches are inevitably enhanced or limited by the purpose, policy, procedures, material resources and staff available within their organisation. This suggests that it is not that social work lacks 'professional' theory, or that it is uninformed by research-validated theories, but that the lack of opportunity to apply theory, owing to organisational constraints, could result in a lack of credibility concerning these matters.

Thus theory is seen to carry important functions in social work. It can inform practitioners and agencies as to the most effective interventions. If it is explicitly articulated it can enable others to understand and appreciate the rationale for intervention. It can give credibility to social work when it indicates that practitioners have used intelligent judgement in deciding upon their course of action. However, the use of theory varies between practitioners; and the extent to and manner in which theory is used is affected by employing agencies.

The Need to Synthesise Theory with Practice

CCETSW was convinced by the argument that the ability to use and contribute to the development of theory was essential for competence, expertise and professionalism in social work. In CCETSW's analysis of courses in the early 1970's, it identified a wide range of different knowledge and skill bases that had evolved in various social work specialisms, and a wealth of diverse theoretical material and practice emphases that had been developed by these specialisms. Thus, the synthesis of this theoretical material with practice skills became a key objective for CCETSW in preparing course guidance for a generic qualification.

CCETSW (1975) concluded that for social workers to be adequately prepared for generic practice they needed to be equipped with knowledge of a range of alternative theoretical models and how to apply them. Furthermore, they required an enormous and expanding amount of

knowledge concerning legislation, social policy, social administration and the needs of specific client groups. CCETSW also concluded that practice competence in social work required students to learn how to combine these different aspects of knowledge - theoretical and practical - with direct skills. Thus, while acknowledging the increasing calls from agencies for direct skills training to be included in social work education, CCETSW also considered it essential to maintain the strong links that the academic institutions had established between theory and practice. Only by doing so would CCETSW be able to convince others that the training was of sufficient intellectual rigour.

The manner in which CCETSW aimed to achieve this synthesis is important. The training organisation faced apparently contrasting expectations from employers on the one hand, and course organisers on the other. Employers considered that more time should be devoted to teaching direct practice skills in order to improve social work competence. However, course organisers argued that an understanding of how to use and develop theory provided the foundation for competent practice. In an effort to prevent a widening of discrepancy between the views of employers and colleges, CCETSW promoted greater collaboration between course tutors and practice teachers in the field. It encouraged collaborative initiatives such as the reversing of roles for tutors and practice teachers and joint seminars. It also established a requirement that colleges should arrange an even split between academic study and fieldwork practice placements for all students on qualifying courses. The requirement of an even-split between academic study and practice placement aimed to achieve recognition of the essential synthesis of knowledge and skills in social work.

While requiring this collaboration between colleges and agencies, CCETSW was otherwise anxious not to restrict course providers in developing their curricula. CCETSW

considered it important, at a time when the demand for and scope of social work were both expanding, that the evolving and dynamic aspects of social work should be recognised. CCETSW wanted to avoid presenting social work as a profession in a static state. While the training organisation's primary concern lay with satisfying employers, it strove also to ensure protection of, and continuing development in, the professional status of social work. To this end CCETSW encouraged educationalists to make creative use of the growing knowledge sources available to develop the profession further. CCETSW was eager for colleges to explore the 'synthesising elements' in social work, and to organise them into models for teaching and practice in a manner which was creative and which would lead to new insights and new theoretical approaches.

Defining the Essence of Social Work

To facilitate the flexibility necessary for such creativity, development and professionalism, while also ensuring that the criticisms of social work training were addressed, CCETSW developed guidance for course providers in the preparation of their curriculum and in the assessment of students. This was based upon a working definition of social work that was intended to reflect the coherence of social work practice across different specialisms. Because social workers needed to be prepared for many different areas of work, CCETSW faced the key task of developing guidance suitable for generic training that integrated the different knowledge and skill bases and ordered the theoretical material and diverse emphases from the various specialisms. However, CCETSW found difficulty in achieving this and concluded that:

Social work cannot be reduced to a core or essence... it is important to recognise that the fundamental principles, concepts and knowledge may be variously united with differing elements of skill in various configurations of practice (1975:18).

Nevertheless, CCETSW identified certain procedures and essential components of knowledge, skills and values that appeared to characterise all social work whatever the setting or model of practice used. These were used to develop the guidance for the 'core content' of the CQSW, which became the standard professional qualification in 1972. CCETSW otherwise permitted and encouraged diversity so long as course providers were explicit about the aims, objectives, values and models which they advocated on their courses. CCETSW maintained that this should be reflected by encouraging students to 'make explicit their own values and theoretical orientations'; and this required students to develop their capacities of thought, judgement and expression.

At the time, it was important for CCETSW to be clear about the content and standards of training courses so that employers could know what levels of competence they could reasonably expect of practitioners at different stages in their training, i.e., whether unqualified, newly qualified or experienced. This clarity was also needed later in directing colleges in the preparation of the modular training scheme for the Certificate in Social Service (CSS), which was introduced in 1975. Unlike the CQSW, the CSS was not intended to professionally qualify individuals to practise in social work (Butrym 1976). The CSS was designed for staff already employed in settings other than fieldwork, for example in day care, domiciliary or residential care. The development of this course reflected recognition of the fact that in many areas of local authority social services the tasks did not require professionally qualified social workers. Because CCETSW intended also to promote post-qualifying education it was essential that it achieved some clarity concerning the expected content and standard for these two distinct courses.

Too much to learn, in too little time

The vast amount of knowledge relevant to social work practice presented CCETSW with the very difficult task of deciding what to include in the course curriculum. With such a large number of disciplines contributing to social work knowledge - developmental, social and general psychology; sociology; philosophy; political science; law; social anthropology; economics; medicine; psychiatry; education, social policy and administration; literature and art - and insufficient time for learning, CCETSW concluded that it was most important that students received opportunities to 'integrate the knowledge from each discipline... [and to] make full use of it in practical situations' (CCETSW 1975).

Given the pace of change in social work practice, and the explosion of knowledge in the social and behavioural sciences, CCETSW considered it was most important that students should learn how to learn. Training could make them aware of the main areas of knowledge used in practice, but they needed to be prepared to enlarge upon these in developing more specialist interests. In taking this stance, CCETSW sought to reassure employers and other professionals that qualified social workers would have a comprehensive knowledge base that would be of practical value in their interventions, and which they could supplement as required. CCETSW also emphasised that because the 'conscious use of self' was important in all forms of social work, their learning experiences would reflect the need to develop self-knowledge and self-awareness. In this way CCETSW sought to establish social workers as professionals who could be insightful and flexible in response to need, and also reflective and explicit concerning their choice of intervention in individual situations.

This approach by CCETSW of helping students develop their abilities to learn effectively and to supplement and update their knowledge after qualification was similar to that taken by

other professions. The explosion of knowledge in the medical sciences, as well as relevant developments in the social and behavioural sciences, meant that doctors, nurses, and other professions allied to medicine, also needed to continuously update their knowledge to keep on top of their fields. However, there was an important difference in the rationale for this between social work and these other professions, which had more time available for initial training. CCETSW was acutely aware that the time available for social work training was insufficient to cover everything students needed to learn in order to prepare them adequately for the wide variety and complexity of the casework that they would carry in the field (CCETSW 1975). Thus, the emphasis on continuing learning after qualification seems to have been as much about 'catching up' later, to make good the gaps in initial training, as it was about developing more specialist interests and keeping up with knowledge. This requirement for students to cram considerable knowledge within a short time, and to learn whatever else they needed after qualifying, does not seem consistent with CCETSW's attempts to convince others of the adequacy of their training, or the professional status of those who completed the course.

Essential Knowledge and Skills for Collaboration

CCETSW demonstrated the importance it attached to preparing social workers for interprofessional collaboration by including several elements of the subject in the new training syllabus. The following details are significant to this thesis as they show the knowledge and skills that social workers could expect to learn during qualifying training, and which other professionals could expect to witness in practice.

CCETSW stated that social workers, having gained some experience soon after qualifying, should have the ability to share knowledge about theory, skills and practice with other

professions. The training organisation considered that this ability would be demonstrated through social workers' capacity to:

1. facilitate communication and trust between professions and workers;
2. draw on the knowledge base of other professions and workers;
3. identify changes, common elements and differences in practice or skills;
4. elucidate commonality and differences in values, priorities and accountability;
5. clarify for others the essential components and the strengths and weaknesses of social work practice.

CCETSW considered that because social workers would frequently collaborate with other professionals, they should develop knowledge of:

The theoretical and value bases from which other disciplines and professions function, the extent and limitation of the services they are able to provide, and an acquaintance with their levels of education, training and qualifications, and of the techniques and procedures which they use most frequently in providing services (1975:26).

CCETSW also argued that because social work 'judgement' was open to challenge from others, who may have different values and skills, it was important that qualifying courses enabled them to develop confidence in their judgements and an ability to explain them for other professionals.

Thus, in preparing detailed requirements for courses, CCETSW granted to employers and other professionals the expectation that qualified social workers would be well prepared for interprofessional collaboration - that they would be confident in articulating their contribution, their values and their role, and they would know about the roles of others and their agencies.

Proof of the Pudding!

While CCETSW endeavoured to convince government and employers of the credibility and adequacy of social work training by establishing course requirements, the ultimate criterion lay in whether the colleges successfully prepared social workers to perform the duties required by employing agencies. However, throughout the 1970s there were continuing criticisms of social work failings and consequent concerns expressed about the adequacy of social work education and training (CCETSW 1987). The difficulties course providers faced in meeting the training needs of social workers to address practice weaknesses were compounded by rising demands for additional training to prepare students for increased responsibilities arising from new legislation. Meanwhile, employing agencies pressurised CCETSW to be more specific about exactly what social workers would learn on qualifying courses. They expected CCETSW to establish direct links between student learning and the essential requirements of practice.

Thus, in 1981, CCETSW began a further review of qualifying training, (which continued over a six year period). At the conclusion of this review, CCETSW argued that the two year training period was wholly insufficient for qualification courses and they proposed a new three year training scheme for qualification: the Diploma in Social Work (DipSW).

It is important to discuss the DipSW in this thesis to show how CCETSW responded to continuing criticisms and increasing demands. It is also important because the changes in social work training may have made influenced the opinions of those professionals who are surveyed in the research for this thesis.

Reform and the Diploma in Social Work

In reviewing qualifying training, CCETSW undertook extensive consultation with representatives of specific client groups. It concluded that the continuing criticism that qualifying training failed to adequately prepare students for field work was justified. Significant to this thesis was a request from the learning disability organisation, Mencap, that CCETSW ensure that social work qualification courses took more notice of the needs of learning disabled people. Mencap argued that all staff working directly with learning disabled people and their families should:

Become thoroughly skilled and proficient in methods of helping people with handicaps to learn and develop their skills and abilities. Social workers should be able to inform parents of provision of services from the time of the child's birth and on through to adult life (CCETSW 1987:16).

Mencap's argument was supported by the work of others who had also found deficiencies in social work with disabled children and families. For example, Browne's (1982) research, which was partly discussed in Chapter 5, revealed that many of the skills that social workers used with other client groups were not being applied in disability work, and that consequently families received a lower quality of service. Browne's research revealed relevant issues for this thesis about social work training. She found that disability work attracted little interest among the social workers she interviewed. She expected that social workers would blame their limited involvement with disabled people on the lack of time available to them after dealing with crisis work and statutory demands. However, she found instead evidence of limited understanding about the impact that disability has on family functioning and relationships, and uncertainty among workers about how to develop their role with disabled people. This position raised vital questions for education as well as practice in the 1980's.

Browne acknowledged that CCETSW faced a difficult task in preparing students for basic competence across a wide range of problems and that, because of this, it had to consider what could safely be left over for post-qualifying training. Nevertheless, she asserted that disability training was essential at qualifying level. Her rationale for this argument was that the content of qualifying courses should be inseparable from the immediate requirements for practice. Browne also warned that unless social work training in disability was complemented by supervised fieldwork, and reinforced by the acknowledgment of agencies concerning the importance and complexity of the needs of disabled people, then the knowledge and skills required would be lost to social work.

In other areas of children's services during the 1980s, existing training programmes were perceived to have failed to provide the education and training needed for the increasingly complex demands imposed on social workers. Referring to evidence from the Jasmine Beckford child abuse enquiry (1985), CCETSW stated that:

Some of those holding existing qualifications who are given professional and statutory responsibilities to protect the vulnerable have demonstrably lacked the knowledge and skills to do so (1987:10).

CCETSW conceded that the arrangements for training that had been based on the circumstances and needs of the 1970s, with its traditional focus on face-to-face work with individual clients, was no longer appropriate for equipping social workers with the knowledge and skills they required. Social workers increasingly needed to take account of new legislation and government policies, demographic change, different social problems such as drug, alcohol and substance abuse, sexual abuse, HIV and AIDS, and service reorganizations (including work in multidisciplinary teams). CCETSW argued that the government made insufficient resources available for courses to cater for the scope of training requirements. Furthermore, agencies'

inability to provide sufficient practice learning opportunities meant that students were failing to learn how to properly relate theory to practice.

To overcome these problems, CCETSW proposed that existing CQSW and CSS courses be integrated into a new Diploma in Social Work, with a renewed and increased emphasis upon partnership and collaboration between colleges and agencies. The training body argued that this would facilitate a greater uniformity within teaching programmes and raise the standard of social work knowledge and skills. However, for this to be achieved training courses also needed to increase in duration and depth. In comparison to doctors, teachers and other caring professions, only social workers have a standard two years' training. Thus, CCETSW proposed a diploma of three years study, which would allow students to develop skills and prove competence in the planning and practice of their interventions, and in the evaluation of outcomes. CCETSW argued that to achieve competence, students needed sufficient time to follow through their interventions under supervision. In addition to the three-year duration, CCETSW recommended students undertake an extended practice placement. This greater depth in education was considered essential for social workers to 'develop the confidence to work alongside other professionals in multi-disciplinary teams.' Thus CCETSW established its aim that all newly qualified social workers would be 'prepared for effective and accountable professional practice' (CCETSW 1987).

The New Diploma

CCETSW prepared a new definition of social work and identified a 'common core' of knowledge, skills and values that it considered applicable to all social work settings. CCETSW argued that qualifying training should focus on ensuring competence within these core areas

(CCETSW 1991). Within the new definition, there were a number of new emphases that have particular significance in this debate about the social work disabled children. CCETSW highlighted social workers' responsibility to promote equality for every age, gender, sexual preference, class, disability, race, culture and creed. It also stressed social workers' responsibility for making proper use of resources available in the wider network of health and welfare provision for their clients' benefit. CCETSW placed new emphasis on the importance of interprofessional collaboration in social work. It stressed the need for qualifying training to enable social workers to develop their knowledge of the roles, contributions, theoretical perspectives and value systems of other professionals.

Essential Knowledge, Skills and Values

Within its 'Rules and Requirements' for the DipSW, CCETSW tried again to provide students, colleges, employers and all other stakeholders with clarity about what they could expect from a newly qualified social worker in all settings and sectors (CCETSW 1991). CCETSW made 'key statements' concerning those aspects of social work knowledge, values, core skills, competencies and areas for understanding that it considered essential for students to acquire in order to 'develop the reflective and analytical approach essential for a professional worker' (1991:1.11).

These essential aspects were presented in a 'statement of requirements' for qualification, and described as: core knowledge, values and skills; competence in assessing, planning, intervening and evaluating outcomes; competence in working with individuals, families and groups over a sustained period in an area of particular practice within the relevant legal and organisational frameworks; and competence in transferring knowledge and skills to new

situations and in taking responsibility for professional practice. CCETSW made key statements about each of these aspects and described in detail the specific areas for learning that each required. The following statements have been selected for comment here because of their particular relevance for social work in co-ordinating multidisciplinary assessments for disabled children and families.

In the key statement concerning core knowledge, CCETSW stated that social workers:

...need a rigorous approach to the acquisition of knowledge. They must become confident in identifying, locating and using relevant source material - factual, general, specialist and research. They must be able to conceptualise, to reflect, to analyse competing theories, ideologies and models of practice which will inform their work (CCETSW 1991:2.1).

Five key areas of knowledge were identified for study: social work purpose, models, methods, settings and theory; values; law, including statutory duties, powers and legal principles; applied social sciences; and the organisational context of welfare.

Regarding the last of these, CCETSW emphasised the importance of interprofessional collaboration. The training body reiterated that social workers should develop their knowledge of social work within the wider context of a network of social service, health, criminal justice and penal provision. Thus training was intended to enable them to understand the structures of, and inter-relationships between, central and local government, the criminal justice system, and other statutory, voluntary and private bodies. The importance of collaboration was further highlighted in the key statement concerning core skills. CCETSW considered that social workers needed to learn a wide range of skills in order to:

Provide help to those seeking or referred for a service and for effective partnership with members of the community offering and using services, and collaboration with colleagues and workers in other organisations (1991:2.3).

These skills included cognitive, interpersonal, decision-making and administrative skills, and an ability to use resources creatively. Most notably, an objective of social work training was to help students develop their proficiency in negotiation, networking, and partnership working, and their ability to identify decisions that required prior consultation and collaboration with other agencies and professionals. Social workers would then be able to ‘Contribute to the formulation of programmes of care in collaboration with users, carers and other professionals...’ and to ‘clarify the mutual responsibilities of all involved in the implementation of such programmes’ (1991:2.4.2).

CCETSW also considered it essential that students developed an awareness of the potential for conflict in collaborative working between organisational, professional and individual values. Regarding social work values, CCETSW perceived that these were best expressed as:

...a commitment to social justice and social welfare, to enhancing the quality of life of individuals, families and groups within communities, and to a repudiation of all forms of negative discrimination (CCETSW 1991:2.2).

CCETSW considered that competent practice requires social workers to understand, commit themselves to, and integrate these values in their workplace. CCETSW considered that social workers should have a commitment to ‘the value and dignity of individuals; the right to respect, privacy and confidentiality; the right of individuals and families to choose; the strengths and skills embodied in local communities; and the right to protection of those at risk of abuse, exploitation and violence’ (CCETSW 1991: 15). The objective of qualifying training was to help social workers develop their abilities to ‘counteract the impact of stigma and discrimination’ and to ‘promote policies and practices which are non-discriminatory and anti-oppressive’ (CCETSW 1991:16). Moreover, training would enable them to develop their ability to explain for others

how values inform their interventions. These points have particular significance because they reinforce the findings of the discussions in Chapter 4 concerning the importance of the social work role in promoting the social model of disability (Middleton 1996).

Competence in Social Work Practice

CCETSW considered that competence in social work practice was the product of the synthesis of the core knowledge, skills and values that they identified (CCETSW 1991). To gain qualification, social workers were expected to be capable of demonstrating competence in the following practice areas: assessing needs, strengths, situations and risks; planning appropriate action; intervening to provide an initial response; implementing action in an area of particular practice; evaluating actions; transferring knowledge and skills to new situations; and taking responsibility for practice. The idea of an area of 'particular practice' was a new initiative in social work qualifying training. One significant reason for CCETSW introducing this requirement was to demonstrate to employers and others that the training equipped qualified social workers with the ability to apply core knowledge, values and skills, and additional relevant knowledge, to different fields of work.

Qualifying social workers must be able to...select methods appropriate to the assessment, planning and purpose of interventions... help, provide care for, counsel, supervise, protect, individuals and families in difficulties... understand and counteract the impact of discrimination... understand and where necessary take part in procedures for inter-professional collaboration... [and] evaluate progress on a plan of action with all those affected and directly involved (1991:2.4.4-5).

While CCETSW did not claim that this constituted 'specialist' training, it did intend that such a requirement would provide others with evidence of how core knowledge, skills and values could be applied in various practice situations by competent qualified social workers.

Overall, CCETSW intended that its precise statements of requirements for the DipSW, combined with this idea of students proving their competence in an area of particular practice, would provide employing agencies, other professionals and the public with clarity about what they could expect from a newly qualified social worker. However, as noted above CCETSW had serious concerns that the two year training period was insufficient to prepare students for the substantial, and perhaps unrealistic, expectations that employers and other professionals might have of them. CCETSW asserted that the DipSW would prepare social workers for a competent but basic level of professional practice, but it had no control over the expectations newly qualified workers would meet in employment. Clarifying what could be expected from newly qualified workers was quite a different matter to ensuring adequate preparation for what might be expected. CCETSW's arguments for a third year for training demonstrated the training body's concern that the measures it was taking to address criticisms of training ran a poor second to an extra year. But the government refused to fund a third year. They agreed only to make enough finance available for the conversion of CSS courses and for extending one-year postgraduate courses to two years.

This restriction on the time available for training placed limitations on CCETSW's aims for the credibility and professional status of social workers and their training. With insufficient time available to learn everything needed for generic social work practice, something had to give. If CCETSW was going to achieve its aims, it needed to find other methods for ensuring that social workers could develop the necessary knowledge skills and values. Moreover, these methods would need to convince others. CCETSW's answer to this dilemma was to place a strong emphasis on social workers' responsibility for their continuing professional development (CPD) and the expectation that employers would support them in this.

Post Qualifying Education and Training

In 1990, CCETSW prepared detailed requirements for the Post Qualifying and Advanced Awards in Social Work (PQ awards). The government supported the development of these schemes, which all qualified social workers would be encouraged to follow in order to achieve and evidence their professional progression. These developments ran in parallel with initiatives to improve the quality of practice-based skill-learning opportunities through accrediting practice teachers and approving agencies for placements. This was further supported by CCETSW encouraging increased partnership working between colleges and employers (CCETSW 1992).

Thus, CCETSW developed a framework for CPD, which placed the DipSW on a continuum of social work education and training. The PQ awards were designed to complement social work learning via other avenues, such as employers' in-service training programmes and postgraduate university studies. The framework emphasised reflective practice, critical thinking, research and research-minded practice; and offered four routes to PQ awards: practice, education and training, management and research. The idea was that social workers could gain credits towards their PQ awards by providing evidence of their contribution to the review, evaluation and development of practice and/or of more advanced learning in specific areas. Throughout this education and training continuum, CCETSW continued to stress the importance of social workers using theory to inform practice. CCETSW was keen to see social workers using the PQ opportunities to expand and generate theory to improve knowledge about effective practice interventions, and to progress their skills in explaining the theoretical rationale for any course of intervention.

The PQ framework was based on the expectation that social workers would be committed to their CPD. The PQ Award, the first level of qualification following the DipSW, was intended

to provide opportunities for social workers to extend the skills they had attained at qualifying level. CCETSW expected that all workers who had obtained a professional qualification in social work should be able to achieve this level. Some workers were also expected to move on to the Advanced Award where their 'ability to provide leadership and special expertise' would be recognised (CCETSW 1992).

As with the requirements for the DipSW, the PQ framework was intended to provide clarity about the standards that could be expected of social workers with PQ awards. However, CCETSW was cautious about making claims for the success it hoped for in improving social work professionalism from these measures. The training body pointed out that workers' potential to achieve PQ awards relied not simply on individuals' abilities but also on sufficient support, training and funding being committed by employers and government (1992:5-6).

CCETSW's efforts in these respects are significant in the debate concerning the relevance of social work professionalism in overcoming difficulties in collaborative working. CCETSW aimed to achieve credibility and status for social work. In doing so, it challenged the limitations facing social work and made the best of what was available. Following the trail of other established professions, the training body developed this framework for CPD, which offered individual social workers opportunities for recognition of their advanced knowledge and skills, and encouraged agencies to invest in the professional progression of their employees. Thus, if social workers found that their qualifying training had not adequately prepared them for child disability work, they could look to the PQ scheme and their employer to support them in developing the knowledge and skills required.

The Backlash Against the DipSW

In 1995, CCETSW had to make changes to the DipSW. This was partly because of what Dominelli (1998) refers to as a 'backlash' against CCETSW's promotion of anti-oppressive practice in social work training. According to Domenelli, this backlash was led by government ministers at the highest level, and was instigated because anti-racist and other anti-oppressive approaches to social work practice were viewed as inconsistent with using the welfare state to meet economic rather than social needs. CCETSW were castigated by politicians and the media for their lack of realism in promoting anti-oppressive practice as an essential course requirement while employers were still complaining that students were leaving college inadequately prepared for the complexities of field work.

The consequent revisions to the requirements for the DipSW were founded much more upon a competence-based approach. CCETSW introduced a new framework where students' achievement of competence in six core areas could be viewed as providing evidence of their professionalism. These revisions strengthened the focus on the direct assessment of students' competence. Thompson (2000) draws attention to the tension between supporters of and antagonists against this sort of 'competence-based' training. Although the debate will not be explored here, it is useful simply to highlight some of the implications of this approach.

The Competence-based Approach

Those in favour of competence-based training argue that it provides clarity about the learning undertaken, and enables students to produce evidence of their ability to apply their learning in specific areas of practice. Those antagonistic to the approach argue that it oversimplifies matters that require more thought and analysis to achieve the depth of understanding

required for practice in complex and uncertain human situations (Gould and Taylor 1996). This latter perspective has significance for this thesis and so it is explored in more detail later in the chapter.

In aiming to satisfy the demands of employers and to overcome the limitations of a competence-based approach, CCETSW included in its assessment framework the specific requirement that students provide evidence of their 'professional competence'. In fact, CCETSW gave considerable weight to this requirement by establishing it as one of the six core competencies. Students were required to evidence professionalism by managing and evaluating their own capacity to develop professional competence. This required them to critically evaluate and develop their own practice, appraise research findings and integrate well-tested outcomes into their practice. In this way CCETSW aimed to promote the DipSW as a qualification that prepared social workers to meet the demands of complex practice where high professional standards were expected.

However, in order to reinforce the need for employers to recognise that the DipSW lay at the beginning of the professional training continuum, CCETSW stressed that newly qualified workers would need induction, supervision and further training from their agencies before they should be expected to undertake complex social work tasks, such as child protection and statutory mental health work (CCETSW 1995). CCETSW argued that employers should provide social workers with a planned programme of professional development, which built upon the DipSW and linked with the PQ awards.

This approach of CCETSW has particular significance for the thesis that social workers have the potential to address weaknesses in their practice and to overcome collaborative difficulties that arise from issues of status and credibility. CCETSW was far more forthright

about the goal of professionalism: of social work achieving professional status, of social workers 'being professional'. By emphasising the responsibility of individual social workers for their professionalism, and by placing the onus on employers to be realistic about their expectations and to provide social workers with the means to support their professionalism and progression, CCETSW's approach contributes to the realisation of social work potential.

The Importance Of Continuing Professional Development

In 2002, the education and training, monitoring and regulation, of the social care workforce is set to undergo further substantial change. These changes have been described as a 'revolution in social care' (Steele 2001).

Steele (2001) considers that CCETSW has placed its strongest ever emphasis on the need to improve qualifying training and to develop opportunities for workers to progress their knowledge and practice throughout their careers. CCETSW had been concerned that social workers' interest in PQ training was slow coming during the 1990s. However, the training body report a substantial increase in registration for this training in recent years, with interest being particularly great in studying for the child care award.

Steele (2001) considers that a number of factors offer hope that the importance of the PQ awards will be further recognised. These include the plans to expand opportunities for degree studies in social work, the requirement for social workers to register with the new General Social Care Council/Care Council for Wales and to maintain their registration by providing evidence of continuing professional development.

Despite CCETSW's efforts to improve training, there is evidence that employers continue to be dissatisfied with the quality of newly qualified social workers (Robb 2001). This finding

highlights the particular importance of CCETSW having achieved its aspiration to a three year qualifying training course. Meanwhile, the requirement for registered social workers to provide evidence of their professional progression heightens the importance of the PQ initiative.

However, research has found that only about a quarter of social workers feel that their employers value their achievement of PQ awards (Greater London PQ Consortium 2001). In fact many of the social workers surveyed reported feeling unsupported by their managers while undertaking these awards. Nevertheless, the researchers found an impressive continuation in level of commitment towards their clients among those social workers undertaking PQ studies. These social workers were found to give a considerable amount of their own time and money to achieve the awards while trying very hard to do a professional job. The researchers concluded that many social workers gained their awards 'in spite of their organisation'. The researchers found that, because employers were focused on short-term imperatives, they lacked vision about how the advanced social work skills acquired through PQ studies could be used to improve the quality of social care. These are particularly important findings to consider for this thesis, as they highlight the importance of individual commitment to professionalism and how such a commitment enables social workers to fulfil their potential. Yet the findings also suggest that this potential cannot be fulfilled unless and until employers appreciate the value of continuing professional development and provide support for individual effort.

CCETSW argue that if employers support continuing professional development they can expect social workers who are able to develop more skills and gain greater insight, through reflection, evaluation and critical thinking about their interventions, all of which can be used to raise the standards of practice.

Others have argued that advanced professional knowledge is in fact essential for all competent and effective practice. Cournoyer (2000) argues that because of the enormous breadth and depth of current and new knowledge social workers personally and collectively need to stay abreast of this in order to improve practice. Cournoyer argues that social workers must, therefore, engage in lifelong learning and develop critical thinking skills, which are essential for 'determining the relative validity, reliability, and relevance of new information for professional social work service' (2000:12). He argues that such skills are an essential component of the professional integrity that enables social workers to be entrusted with responsibilities for serving vulnerable people; and he asserts that:

Unless you as a social worker continuously and aggressively pursue additional learning, you will inexorably fall further and further behind the knowledge curve. If you do not continue to learn throughout your social work career, clients could suffer due to your ignorance of services or approaches that might help (2000:27).

The Necessity of Continuing Professional Development for Social Work

It was established above that, despite the emphasis on lifelong learning and critical thinking, there is evidence that social workers make insufficient use of research and theory after qualifying (Coulshed 1991; Thompson 2000). The evidence is that many social workers prefer to deal with the uncertainties in their work by adopting 'common sense' approaches. These may have value, particularly where they have been developed through practice experience or adopted from the traditional tried and tested methods of their service. However, the concern of some writers in this field is that such apparently 'theoryless' practice can undermine social work credibility. Thus, as discussed earlier in this chapter, other professionals might not accord social work higher status because they do not perceive that social work practice makes any great intellectual demands of social workers.

In this vein, Middleton (1996) and Dominelli (1998) argue that while social workers persist in their failure to make use of and articulate theory, and while they continue to be inconsistent in their exercise of anti-oppressive practice, they will not be providing others with evidence of reflection, critical thinking, analysis, application of intellectual rigour or professional judgement in their work. Instead, others will witness the application of somewhat indiscriminate rules, apparently based on 'gut-feelings'.

Arguably, Middleton and Domenelli's writing suggests that continuing professional education plays a crucial role in enabling social workers to achieve recognition for the intelligence that informs their interventions. Opportunities on the education and training continuum, which CCETSW promoted, can enable social workers to advance their skills in developing, applying and articulating social work values and theory.

The work of Gould and Taylor (1996) suggests that a perception that theoretical knowledge has no significant role in social work practice - the focus being on practical knowledge - may be reinforced by the phenomena of 'intellectual reductionism'. This term describes the process wherein knowledge, skills and values are all treated simply as 'competencies' on a functionalist checklist. Gould and Taylor argue that this reductionism has severely affected social work education. The consequence of this, if it has been happening to a substantial degree, is that critical analysis and broader professional education are down-graded. Social workers might not develop the critical thinking required in order to challenge the normative context of their practice. Thus continuing professional development can play an important role if it helps the social worker to move beyond a simplified 'competencies' approach to learning. If it does, then studying for PQ awards and higher degrees can be valuable in enabling social workers to develop the skills that Middleton and Domenelli consider critical to

the fulfilment of their role and the status of the work. It is also possible that continuing professional development may enable social workers to develop methods and methodologies that are more appropriate for research, intervention and evaluation in social work (Thompson 2000).

In this vein, Thompson (2000) argues that it might be possible for social workers to overcome the difficulties they face in gaining credibility for their research and theory (because of the very uncertain and complex nature of their work) through the development of alternative approaches to the investigation of social phenomena and social work interventions. The following discussion considers Thompson's argument and builds on the issues raised by Kitwood (1990), which were explored in Chapter 4.

Advancing Professionalism through Continuing Professional Development

In chapter 4, the exploration of the process of professionalisation revealed the significance given to the use of scientific methods for researching and validating professions' interventions. It was noted that to gain recognition the newer professions followed the patterns of other established professions, by ensuring that their theories were accepted as scientifically valid and reliable. Thompson (2000) argues that difficulties arise for social workers researching and evaluating practice because of the prestige given to work considered to be 'scientific', which has traditionally been regarded as superior to other forms of knowledge. Thompson observes that by implication such work is seen also to be 'authentic, authoritative and true'. This prestige has generally been achieved through the adoption of a positivist approach to investigation (Kitwood 1990; Gould and Taylor 1996; Thompson 2000).

Thompson (2000) has explored the reasons why the positivist approach has held such sway among the professions and why this creates problems for social work. The approach is

characterised by the belief that universal laws can be discovered through scientific investigation; by a commitment to 'objective', observable and measurable factors (and a mistrust of subjective factors); by a view of science as a morally neutral or value free enterprise; and by a commitment to empirical research as the most appropriate form of investigation. Thompson observes that:

Positivism has been a major influence in the philosophy of science over a significant period of time. Although less dominant now than in the past, positivism remains a pervasive influence at both an explicit and implicit level. It is therefore important to be clear about the problems inherent in adopting a positivist approach, so that we are not carried along uncritically by the force of positivist tradition (2000:44).

The positivist approach has serious weaknesses in its application to social work practice - and in all kinds of intervention in human lives - because substantial uncertainty and chance combine with the subjective experiences and interpretations of both clients and practitioners. Thus, if social work investigations and theoretical frameworks are to possess the power to explain social and psychological phenomena they need to reflect these features. As Thompson (2000:44) stresses: 'Social and psychological phenomena cannot be squeezed into an inappropriate frame of reference.'

Consequently, social work has needed to adopt or develop alternative approaches to investigation, and to seek recognition for their validity, reliability and explanatory power, within frames of reference that do not sit easily with those who place their faith in a positivist or empirical science. Gaining recognition for valid theory has been further complicated by the failure of social work to fully embrace other more appropriate approaches, and to integrate findings from social work research into day-to-day practice.

In recent decades, alternative approaches and frames of reference for research and evaluation have evolved that emphasise the particular value for social work in giving priority to user perspectives. For example, Silverman (1985) and Bryman (1988) both emphasise the

importance of researchers selecting methods that gather data that reflects the subject's way of seeing the world. Everitt et al. (1992) argue that this may be achieved through such methods as service-user consultation and action research. These and other perspectives are considered in detail in the next chapter.

However, despite these insights concerning the need for alternative approaches for conducting social science research, social work continues to have difficulty in establishing them. Broad (1999) argues that research and evaluation in social work are under pressure from different stakeholders who often have different agendas. He asserts that the trend towards specialisation and selection in the funding of research in universities can lead to the marginalisation of more structural and critical approaches to social work practice and research. Thus, Broad argues, the more exploratory and innovative methodologies and grounded approaches, which encourage wide participation, may be at risk - either from a lack of funding, or through a process where the values of such approaches are diluted and absorbed into the mainstream. Among those at risk, Broad (1999) includes: user- and carer-driven research, more qualitative research designs, social action research, observational studies, feminist research and research that has explicit anti-discriminatory values. Other writers who have contributed to knowledge concerning the politics of research and evaluation also warn of the threat from gatekeeping and inertia from agencies, which can create barriers to knowledge, research understandings and alternative terms by which social work issues may be defined and addressed (Broad 1999).

Conclusion

The literature contributing to the discussions in this chapter has revealed arguments for and against the thesis that social work has the potential to overcome collaborative difficulties and

its own practice weaknesses. On the one hand, there is evidence of this potential in the measures that CCETSW and TOPSS have taken by to improve the quality and credibility of qualification training, and to increase practitioners' opportunities for continuing professional development. There is evidence of potential in the interest that social workers have demonstrated in these opportunities. The possibility of realising potential is evident in the importance given to the development of theory to inform practice (by CCETSW), and in the opportunities that post qualification training holds for the evolvement of social work specific approaches to research and practice evaluation.

On the other hand, there is evidence that demonstrates a lack of potential because of certain impediments to social work improving practice in child disability work to any significant degree, or to overcoming difficulties in collaborative working. The first impediment evident from this chapter's discussion is that social work students seem to have few opportunities to gain an understanding of the needs of disabled children and families in qualifying training. Secondly, there is evidence that social workers are not making use of theory in practice. This suggests that qualified social workers do not realise the value in the practical application of theory in improving practice, and in gaining recognition for the credibility of their interventions. A third impediment is that of social workers' inconsistency in applying social work values, which suggests that certain distinct and important aspects of their role may not be realised. A most significant impediment is the failure of agencies to support social workers in their continuing professional development. There is evidence that employers' expectations of qualified social workers are increasing, as social work responsibilities become ever more wide-ranging and complex, yet they are failing to provide the support necessary for the professional progression of their staff. Finally, there is an impediment to social work potential evident in agencies' inertia

concerning the development of alternative approaches to social work research and evaluation, without which the possibility of finding new ways of understanding and improving practice is restricted.

Examining the thesis critically, the evidence is that these impediments weaken the potential to improve practice and collaborative relationships. However, other matters noted in this debate offer some possibility for tackling the impediments and realising potential. These include the efforts of CCETSW, and more recently TOPSS, to collaborate with employers in improving the professionalism of social work. The initiatives include facilitating collaboration between agencies and course providers to develop high quality practice placements for student social workers, which provide opportunities to integrate theory with practice; urging agencies to be realistic about their expectations of newly qualified workers; and encouraging agencies to support the professional progression of their social workers. There is also the increasing availability of opportunities for multidisciplinary working and training, which allow social workers to develop their collaborative skills and others to increase their understanding of social work.

There are also more recent developments including a third year for qualification training; the further development of social work degree courses; the new standards and regulations for practice being established by the Care Councils; and the requirement for social workers to register and provide evidence of their continuing professional development.

The central argument of this thesis is that social work potential can only be fulfilled if the impediments to it are addressed at personal, professional and agency levels. The discussions in this chapter suggest that the professional credibility that social workers require to fulfil their

potential and overcome collaborative difficulties can only be achieved if the limitations discussed here are addressed on each level.

This chapter identified certain tensions in the debate concerning the credibility of social work training. Where it is perceived that practice weaknesses arise because of inadequate training, then much of the evidence above of how social work potential might be fulfilled provides an indication of a more optimistic future for training and practice standards, particularly if employers give their support. Where it is perceived that social work has failed repeatedly to address weaknesses, the evidence suggests that more serious commitment is now being given to tackling weaknesses than ever before, with the establishment of the Care Councils and TOPPS.

Where it is perceived that social work training is not, and will not be credible as 'professional', the initiatives to improve the content and quality of qualifying and post qualifying training may have little impact. Where the objections are due to a rejection of social work's claims to appropriate knowledge and skills such initiatives are unlikely to have much effect. Perhaps these practical objections could only be satisfied through the development of training opportunities that enable social workers to develop specialist expertise and to gain confidence in explaining for others the distinctive characteristics of their role and how these have particular value for disabled children and families. Where the objections are more academic, it may be that the nature of social work is such that there might always be a credibility or status gap between it and other professions. Perhaps this is not simply because practitioners deal with uncertainties and complexities, and need to find distinct ways of evidencing the validity of their interventions, but also because of perceptions generally about the purpose and value of social work in modern society. This is not a matter that will be debated here. However, the measures that have been identified in this conclusion as perhaps helpful to social work in fulfilling its potential might also

help improve the credibility of social work in the eyes of others, and hold possibilities for a greater understanding and valuing of the goals of social work.

These important discussions generated two lines of enquiry for the field research: first, an exploration of others' perceptions of social work training, and particularly whether they consider social workers adequately qualified to help disabled children and to facilitate collaborative working; and second, an exploration of social workers' views about their training and whether they consider it equips them adequately for their role. These enquiries aim to reach some conclusions about whether social work training is sufficiently thorough in preparing social workers to practice in this field of work; and whether it is sufficient to enable them to overcome existing practice weaknesses and collaborative difficulties.

Chapter 6

The Research Aims and Methods

The Research Process

The following chapter examines in six sections various matters concerning the research process and selection of the research methods. The first section provides a summary statement of the scope and aims of the investigation. The second section broadly examines the questionnaire and the interview schedule as research methods, giving consideration to some of the advantages and disadvantages in using these methods. The third section explains the researcher's rationale for choosing these particular methods - some of the alternative methods that could have been used are considered and reasons given as to why they were not selected. This section also includes a brief discussion of ethical issues and gives an explanation as to why clients' views on social work and interprofessional collaboration were not gathered. The fourth section examines the advantages of combining quantitative and qualitative methods of gathering data in social science research. The fifth section looks in more detail at the process of designing and piloting the research tools; and the final section discusses the selection of survey respondents.

1. Statement of the Scope and Aims of the Investigation

Purposes of the Research

The purposes of the research and the key research questions were discussed in Chapter 1. In summary, the study enquired into the nature of collaborative difficulties and questioned why they exist; how serious they are; how they are maintained; and how they might be overcome. The research examined practitioners' perspectives on the extent to which collaboration for

disabled children was achieved within a local authority social services area and questioned whether the difficulties reported elsewhere manifested themselves in the locality surveyed. The research questioned health and education professionals about their expectations and experiences of social workers in collaborative care for disabled children and asked them about the training they had received for multidisciplinary working. The research sought insight into collaborative difficulties and matters restricting social work potential by exploring that which underpinned other professionals' understanding about social work and their attitudes and expectations of social workers.

Social workers were also surveyed about their experiences of collaboration, their reflections on practice with disabled children and the adequacy of their training.

The Focal Concern of the Research

Ultimately disabled children and their families were central to the project, yet in considering how their needs could best be met the spotlight was directed upon the social worker as the 'main subject'.

Although disabled children and their families were the 'focal concern', and would be the 'primary beneficiaries' of improved interprofessional working, social workers and other professionals would also benefit from improving practice and thereby gaining recognition and rewards for their skills, hence they would be 'secondary beneficiaries'.

Although the main subject of the research was the individual social worker and the objective was to explore how their contribution could be improved and potential fulfilled, it was recognised that professionals are dependent upon each other and their agencies for the successful implementation of mechanisms for improving collaborative working. This interdependence

meant that although professionals in health and education services were not the main subjects (or primary beneficiaries) of this research, they were important 'secondary subjects' (and 'secondary beneficiaries'). In seeking their views on social workers these other professionals constituted the 'primary source' within the survey from which the main research conclusions were drawn, i.e. they provided the primary source of information about the main subject being examined (social workers), in order to address issues regarding the focal concern (disabled children).

The views of social workers - of their own role with disabled children, and their own experiences of interprofessional collaboration - although central to the research, constituted a 'secondary source', and hence a smaller, though no less important, sample of social workers was surveyed. This was because the main perspective sought through the survey was that of other professionals, that is, their attitudes towards and expectations of social workers in interprofessional collaboration for disabled children.

The Data

The research gathered quantitative data through questionnaires completed by forty respondents from a range of health and education professions whose work entails providing services to disabled children. Qualitative data were also gathered through semi-structured interviews with a further twenty health and education professionals. The final stage of the research gathered qualitative data through semi-structured interviews with ten child care social workers.

The Sample

The sample was selected from a range of health, education and social care professionals, whose work entails providing services to disabled children within one county in West Wales.

A non-probability judgement sample was made, selecting respondents by virtue of their occupational responsibilities and professional experience with disabled children. Non-random selection was justified because of the researcher's familiarity with the locality and local practice with disabled children, which allowed a comprehensive study to be undertaken through the selection of nearly all those professional practitioners whose work entails significant responsibilities for disabled children. Thus the sample included, among others, all members of the local multidisciplinary team, which provides specialist services for disabled children, and key members of the 'Child Development Team', which conducts interprofessional reviews of disabled children in the locality.

The Limitations of the Study

The study involved a small-scale investigation into the views of a range of health, education and social care professionals. It was restricted by time, finance, access to respondents, and by the perceived adverse impact of previous research undertaken within the locality. This last issue is discussed in some detail further on in the chapter.

The time restriction was due to the study being completed in the researcher's spare time, i.e. in addition to full-time employment. However, the employer's permission was given for a limited amount of survey work to be conducted during working hours providing that this did not interfere with employment obligations. No outside sources of finance were available to support the research.

As a consequence of these restrictions the geographical scope of the investigation was limited, and only a small-scale survey was undertaken. Thus non-random sampling of respondents was justified in order to target and thereby guarantee that practitioners who had reason to frequently liaise with other professionals would inform the research; their work entails significant day-to-day responsibilities concerning disabled children and their families. Professionals carrying more generic workloads, such as general practitioners, hospital nursing staff, the police and service managers were not included because they were not required to liaise on a frequent basis with other professionals concerning disabled children. However, the researcher recognises that a broader survey including these professionals' opinions would have provided further valuable insight and hence their omission is acknowledged as a limitation.

Finally, the substantial amount of survey work that has been undertaken in the locality over preceding years, which has gathered the views of parents and carers of disabled children about service provision, also led the researcher to conclude that the research should be restricted solely to professional practitioners. The researcher recognises that obtaining the perspectives of disabled children and their families could have reaped further valuable insights. However, their omission from the survey is justified by asserting that the main purpose of the research was to contribute to understanding of the relationships between professionals in collaborative working, and hence the survey needed to focus upon the practitioner's perspective. This issue will be discussed below in more detail.

2. Research Methods

The Self-completed Questionnaire

The questionnaire is a useful tool for testing out the validity of hypotheses or theories generated through a review of other research in the field. The researcher looking for an efficient, objective and value-neutral way of ascertaining whether findings from elsewhere can be generalised to their survey sample may find the questionnaire most suitable. Questionnaires can be used in different contexts or environments to test for similarities across them, or they can be repeated with the same sample after a period of time has elapsed to see whether any changes have taken place as a result of new factors introduced. For example, Lloyd, Webb and Singh (1995) gathered information from GPs and social service representatives in examining the impact of community care reforms in general practice. Using questionnaires and interviews before and after the reforms, they successfully identified key issues which merited further discussion at local and national levels; and they generated recommendations for practical measures which could be taken to evolve co-ordinated and co-operative approaches between professionals.

A large number of respondents can be surveyed with questionnaires; and a collection of completed questionnaires can offer up a considerable amount of data for the researcher, which can be used for comparative purposes. For example, one respondent's answers can be compared with another respondent's, or one group of respondents' answers can be compared with another group's. Furthermore, distinct groups of respondents may be separately identified by a defining characteristic, such as age, gender, locality, place in time or, as in this research, by profession. The data collected can also be statistically and descriptively analysed. For example, Collins (1995) used a standard self-completed postal questionnaire as the sole research tool to gather the opinions of parents of disabled children as part of an audit of statutory services in one local

authority. The sample of respondents received their services from different teams across the county; in order to differentiate between the service responses across three teams, Collins utilised bar-charts, simple statistical analysis and respondents' written quotations within the presentation of the results.

Questionnaires can be designed to collect very specific information. The researcher can design questions in such a way as to clearly direct the respondent to choose from a narrow range of alternative answers or responses. For example, a question can be posed to which the choice of answers may simply be 'Yes' or 'No'. Alternatively a range of scores or ratings may be offered for the respondent to choose from that indicate the scope of views about something on a continuum. For example, in the questionnaire for this research, health and education respondents were asked the following three questions: Do you feel that you have sufficient knowledge about the role and particular contribution which social workers make within the planning and provision of services to disabled children and their families? Do you feel that you have sufficient understanding about social workers' knowledge, skills and value base? Do you feel that you have sufficient knowledge of social work training? Respondents were asked to select their reply to each question from a continuum offering: wholly insufficient; insufficient; sufficient; and comprehensive. The number of responses in each category could then be added together, and converted to a percentage figure of the total, in order to give a clear presentation of specific findings.

Questionnaires can also be designed in such a way as to indicate a limit on the amount which the respondent need write in reply to a question. For example, by placing a space which would only permit a sentence or two for the answer, before the next question is given.

There are limitations, however, to the value of questionnaires; and their effectiveness can be significantly impeded through poor design or administration. One limitation is that because questions need to be specific they invite only narrow answers, and consequently the information gained can lack insight and depth. This can, however, be counteracted by combining the questionnaire, which collects a useful quantity of general data, with another research method, which collects more focused qualitative information. Birchall and Hallett (1996) displayed the usefulness of combining methods in various 'phases' of research in their study of collaborative working in child protection. They utilised a literature review, postal survey, case file studies and interviews with a range of professionals, to confirm findings generated across the various phases. It will be discussed later in more detail how a combination of methods was considered most appropriate for this research project.

Further limitations of questionnaires are that respondents may hastily complete them and thereby not give much thought to their answers. Respondents might also omit answers to some questions leaving the researcher uncertain as to why, and unable to categorise the response for statistical purposes (except as 'unanswered'). Researchers may also face difficulties distributing and collecting questionnaires and they may get a low response - they may have to be persuasive with respondents in order to get questionnaires completed. Where questionnaires are sent through the post, perhaps to the head of an organisation for distribution to others, the researcher may also be anonymous to the respondent. This can prevent dialogue about the questionnaire or the research and perhaps act as a disincentive to the respondent completing the form. Bell (1987) has identified a further shortcoming: the gathering of data is dependent upon respondents' ability to express themselves in writing. This can affect all but the most straightforward questionnaires

where simple answers are requested. It may be very difficult for the researcher to check out any uncertainties about what respondents write.

However, a well-designed questionnaire and a valid study can assist in avoiding these problems. For this study the researcher was mindful that respondents with demanding work schedules would need to be motivated to complete the questionnaire. Such motivation could be found by convincing them that their contributions would reap advantages for both them and their clients. How this was achieved will be examined later. One problem, however, which was identified during the analysis of the questionnaires in this study, was that because of the infrequent contact health and education professionals had with social workers many of them left unanswered a section which requested their views on how problems which they had identified in collaborative working might be resolved. The researcher has also inferred that for similar reasons some questionnaires were completed hastily with little detail being provided. Consequently, the combination of research methods - supporting the questionnaire with semi-structured interviews - was valuable in overcoming this limitation.

The Interview Schedule

Interviews can be designed to be open, structured or semi-structured. In open interviews the researcher can allow the respondent to speak freely about the topic of enquiry: few limits need be put upon their expression; and in this way large amounts of detailed information can be collected. However, for practical purposes, such as the restriction of time, and in order to maintain a specific focus to the research enquiry, interviews generally need some structuring.

A structured interview schedule can be very similar to a questionnaire format, with the questions being put verbally to the respondent instead of them filling in a form. The semi-

structured interview design, which was chosen for this study, allows the researcher to be flexible in making use of both open and more structured questioning techniques - limitations can be placed upon the scope of a question, the range of answers required, or the time available for discussion. Such flexibility allows the researcher the advantage of being directive in questioning when necessary, or of exploring in depth a topic raised by a particular respondent which might not have been raised by another. Flexibility in structure may also permit the skilled interviewer to be 'ad-hoc', and perhaps daring in their questioning, if they believe it can reap interesting and relevant information. However, the real advantage of the interview as a research tool lies in the interactions which it facilitates between the respondent and the researcher.

Semi-structured interviews give the interviewer an opportunity to explore the key research questions with the respondent who can, where necessary, answer in detail and with feeling. Likewise the skilled interviewer can identify where supplementary questions could be used to check on assumptions and facts or to provide more useful information and insight. Everitt et al (1992) note how respondents' sense of participation and contribution to research may be heightened by face-to-face contact with the researcher. The respondent's active interaction with the investigator enables the research problem to be 'shared', and allows the researcher to acknowledge the value of the respondent's contribution in a way which is difficult to achieve through a questionnaire or telephone survey (although it will be shown how the researcher shared the research problem with groups of respondents prior to their completion of the questionnaire for this study). Researchers' willingness to make the effort to listen to respondents' views and reflect on the issues with them is also effective in demystifying research and reaching out to disempowered people. Furthermore, the combination of respondents giving their views and the researcher providing them with feedback on the outcome of the study can effectively reassure

respondents that their contribution was meaningful and that the research had value; and this in turn increases the likelihood that the researcher's recommendations will be acted upon. Everitt et al stress the added value of survey findings from interviews in which the researcher engages with respondents as 'people first' rather than as 'subjects' or 'objects' of investigation:

It is far easier to encourage someone to speak openly and honestly, and far easier really to hear what they are saying, if they are accorded respect and treated as people with abilities with something important to offer (1992:94).

The application of this principle should mean that the end-result is more relevant because it truly represents people's views, and thus it is unlikely to end up as 'another dusty report on a shelf'.

However, Everitt et al (1992) observe that research methods can be used for conflicting purposes depending upon the values underpinning the practice, the conduct of the enquiry and the use made of the findings. For example, they query how often people have participated in academic research '...without being aware that their time and knowledge have been exploited and not enabled to see why the conditions of their lives have not been enhanced' (1992:65). These matters take on a particular importance when disabled children or their parents and carers are interviewed, such as, when researchers undertake surveys which aim to guide agencies on how services might be improved. These matters are also important when, as in this research, the workers who provide those services are being interviewed, because it is essential to gain their trust and their willingness to respond positively to the research investigations and conclusions. These matters will be examined in more detail in the next section.

Another advantage to interviews is that the researcher can reflect on the answers provided to questions, and modify the schedule where necessary. Such flexibility was helpful in this study where analysis of the views of different professionals during the pilot and initial research phases

led to additional questions being posed. For example, for a variety of different reasons many health and education professionals considered that social work with disabled children should be undertaken by specialist social workers; consequently, although it was not initially intended, the interview schedules for social workers and other professionals were modified so that their views on this matter could be explored.

As with the questionnaire, interview schedules can be repeated in different environments with different samples, or they can be used again with the same sample after time has passed to see if change has occurred for any reason. Because of these similarities in usefulness for repeating research elsewhere and over time, the interview and questionnaire research methods compliment each other well and are often used in social science research for collecting both qualitative and quantitative data, as with the examples given earlier of the research undertaken by Lloyd, Webb and Singh (1995), and Birchall and Hallett (1996).

Unfortunately there are also a few disadvantages associated with interviews, not the least of these being the amount of time which is required for arranging the interview, travelling to see the respondent, conducting the interview, recording, transcribing and analysing the data. If the researcher has not invested time in designing a good interview schedule, so as to focus discussion upon the questions of most importance, then valuable time may be wasted in gathering unnecessary information.

As with questionnaires, there is no guarantee that the respondent will give the researcher their honest views, or reliable answers. Respondents may even deliberately mislead, for example, by saying that which they think the researcher wants to hear, or that which might put them in a good light, either with the researcher or with the recipient of the final report, who may be, for example, their employer. However, this risk of research findings being skewed can affect

other research procedures such as participative-observation and action-research and this matter will be explored later when these methods are discussed.

3. The Rationale for Choosing the Questionnaire and Interview as Research Methods

As well as assessing the advantages and disadvantages of using the questionnaire and interview schedule as research tools, other methods were also considered for this study. In research concerning interprofessional collaboration great use has been made of alternative qualitative or 'naturalistic' research methods, such as 'participative' or 'non-participative observation'; and valuable research conclusions have also been drawn from case studies. The following section will consider why the interview and questionnaire were selected as most appropriate for this research study, and why use was not made of these other methods. However, attention will be drawn to how other methods indirectly informed the formulation of the key research questions. The reason for not interviewing parents, carers, or children directly will also be discussed in detail.

Using psychodynamic theory to inform her analysis, Hornby (1993) has shown how observations of professional interactions, which also draw on the researcher's own experience of working in various interprofessional situations, can provide a wealth of information about the dynamics involved when professionals negotiate collaborative care. Likewise, Wicks (1998) used participative and non-participative observation combined with 'in-depth' semi-structured interviews in looking at the relationship between doctors and nurses. Wicks shows how the use of these research methods and a range of theoretical approaches for analysis of her data provided insights into attitudes and expectations in collaborative working.

Lindencrona, Sorlie and Iversen (1996) observe that because so many external and internal variables influence interprofessional working, such as the professional background, competence and experience of the people concerned, the management policy and leadership style, age and personality differences etc., researchers selecting a methodological approach need to consider the specific focus and purpose of the research. In evaluating interprofessional seminars for staff working in a surgical clinic they considered whether to use methods to generate quantitative outcomes or to facilitate a qualitative 'goal-approach' from which stated objectives could be evaluated. After considering the specific aims of the research they concluded that instruments were required that could collect data that mirrored individual opinions, statements and reactions. They described this as an 'inductive, qualitative and formative' approach. This provided them with the kind of detailed qualitative information that would be most useful to the team. They made use of 'participative-observation' and 'group techniques' to gather data within the seminars, and they used semi-structured forms with 'guided open-ended questions' for self-completion by respondents. Ultimately they achieved their aim of providing team members with useful information about the value of the seminars in improving openness and understanding between them.

These three examples demonstrate how different approaches can be taken to the study of interprofessional collaboration, and that each have their own distinctive advantages in contributing to knowledge and in generating practical recommendations as to how professionals can break down barriers and improve collaborative working. These examples also demonstrate that in selecting methods the investigator needs to be clear about the purpose and aims of the research.

It was established earlier that the main subject of this research is the social worker, and that the study considers the competence with which social workers are seen to carry out their role with disabled children by other professionals. The aim is to identify difficulties in collaborative working and to recommend what social workers in particular could do to resolve them in order to improve their contribution and fulfil their potential. As with the approaches taken by the researchers in the three examples given, the researcher's own participation and observation within multidisciplinary settings during the early stages of the project gave the researcher confidence that the data required in order to achieve the intended aims of the research could satisfactorily be collected by means of a questionnaire and interview schedule with a range of key professionals working in various capacities. By necessity this decision was also made in consideration of those limitations affecting the scope and scale of the project which were mentioned above.

The researcher's observations and informal discussions with practitioners suggested that specific questions targeted at the key research areas, which had been identified through the literature review, could effectively generate data regarding the origins of attitudes and expectations of other professionals about social work, and about how barriers to collaboration are maintained. The same logic applied to interviews with social workers: specific questions concerning their role with disabled children, their knowledge in the field of disability, the adequacy of their training, and their experiences of collaboration etc., could more than adequately reveal the sources of barriers in collaborative working, and encourage respondents to express their ideas about solutions.

Thus, although the research did not rely on the researcher's own professional experience with disabled children and of working in multi-disciplinary settings, or upon any informal

conversations during the period of study, these matters and the knowledge gained from professional practice motivated the project and informed the selection of the research methods and methodology; although they are not discussed in the results. For example, the researcher observed one of the established barriers to interprofessional collaboration to be corroborated in the locality: that of professionals' lack of knowledge concerning each other's roles. From the perspective of a social worker the researcher observed other professionals' understanding of social work to be limited. However, the researcher also observed there to be little accessible information available about social work services, which might have increased others' awareness, except that which individual social workers verbally contributed within liaison and multidisciplinary meetings - and this relied upon these workers' presentation skills and their realisation of the value in explaining their role and resources. The researcher observed such matters to be complex and multi-faceted involving clinical, sociological and organisational determinants as explored in the earlier chapters of this thesis. This sort of observation shaped the design of the research tools because the researcher considered it important to provide respondents with opportunities to express their views about the different emphases that should be given to these various determinants and any other influencing factors; whilst also serving to generate more specific ideas about how social workers could address the problems.

Thus, as a practising social worker, the researcher's approach was not one of a wholly objective observer, but was more one of a 'research-minded practitioner', undertaking 'social work research' (Everitt et al 1992). From this perspective the approach is one of studying how the social work outcomes for disabled children might be improved through social work-led developments. However, although the researcher's observation of, and participation in, the 'difficulties' associated with inter-professional collaboration inform the study, they are not

identified as a source of data and hence they do not feature in the results. In similar vein, Newby (1977) in referring to elements of participant-observation which he undertook during his study of Suffolk farm workers, describes the findings from his observations as being 'between the lines', in that they crucially affected his understanding, but did not really feature in the presentation.

The selection of research methods and methodology and the manner in which the researcher uses their knowledge and their own presence within the research process is not, however, purely a matter for practical and epistemological consideration, in social science research it is also important to consider ethical issues.

Ethical Issues

In emphasising the importance of considering ethical issues, Burgess (1994) highlights the efforts of the British Sociological Association during the 1980s in drawing attention to the need for researchers to ensure that their respondents ('subjects') gave 'informed consent' and that they were made aware of the object and implications of the research.

The facility to explicitly 'share the research problem' with respondents, through questionnaires and interviews, is an appropriate and an ethically sound method for investigating those aspects of interprofessional collaboration with which this study is concerned. Examining the problem through alternative methods such as non-participative observation would have required more scrupulous attention to ethical issues. Everitt et al (1992) state that in order to ensure ethical research practice the researcher must be above-board about the research issues, respectful of people's rights, judging the truth through rigour and openness, and attentive to confidentiality if required.

The researcher gave serious consideration to using the method of non-participative observation to study attitudes manifesting within multi-disciplinary meetings because such forums presented as highly fertile sources of data. However, two major considerations counted against the making of such effort. The first consideration was a pragmatic one: that this method would require a considerable investment of time during working hours which was not available to the researcher. The second consideration was that of the ethical implications of such an approach: in multi-disciplinary meetings individuals' and agencies' weaknesses, failings and inconsistencies are all on display, bad practice and oppressive thinking are exposed, and can fall victim to the researcher's critical pen. Observation-research runs the risk of being unethical unless the researcher can share the research problem with the subjects and establish mechanisms for checking on assumptions and for sharing any views formulated with those being observed in order to guard against misunderstandings and misinterpretations. One way to achieve this is through open observation, the purpose of which is fully explained to the research 'subjects'. However, the findings here can be affected by individuals acting differently to avoid criticism. In research relative to interprofessional collaboration this concern need not be perceived as substantial because the effect such changes in behaviour have upon the research findings could be counterbalanced by combining the observation with another research method. Furthermore, if the research goal is to identify how constructive interprofessional relationships can be encouraged, and the presence of the researcher is observed to actually 'cause' improved relations this could be interpreted as a positive influence with significance as a research finding. If, however, the researcher is insufficiently mindful of ethical issues and not committed to achieving constructive outcomes for research participants the usefulness of their findings may be impaired.

When permission was requested from senior management to undertake this study, the researcher was told that the Social Services Department (the researcher's employer) would be vexed and displeased if the outcome were to be 'unfair' criticism; the results of some previous research had been perceived in this light. After further discussion it became clear that the concern was specifically to do with the way in which previous researchers covertly gathered their data, and the interpretation they put upon certain observations without checking out facts and assumptions, and the manner in which the results and conclusions were delivered. The criticism felt by the Department, and the defensiveness that it provoked, had the effect of detracting from conclusions which might have helped the Department improve its services.

It is essential to recognise therefore that methods of data collection are not neutral technical devices. Bryman (1988) discusses this issue, proposing that the choice of a particular method indicates an acceptance of a 'package of views about social reality and how it ought to be studied' (1988:124). This leads to the possibility of arguing that there is, or ought to be, a mutual interdependency between epistemology, ethical practice and research methods. However, adhering to hard and fast rules about this could present practical difficulties as the researcher also has to consider the technical viability of any method to their particular research task; and to select methods most suitable within whatever constraints circumstances might present, such as the time or finance available for the project, or access to data sources etc. Hence, the researcher considered that although a participative or non-participative approach to the study of attitudes and expectations in interprofessional collaboration would have been a valid research methodology for a smaller project such as this, it would also have been very time consuming. With the research being undertaken in the researcher's leisure time, consideration had to be given

to the most effective method of obtaining research data which would be both fruitful and reliable, whilst accommodating practical restrictions.

All researchers face some constraints to the scope of their research, consequently the choice of methods and the design of the chosen tools is by necessity influenced and informed by these restrictions. The researcher concluded that self-completed questionnaires and semi-structured interviews would be the most suitable and effective methods in the light of the particular constraints faced. Meanwhile, in considering methodology, these research tools could be used in such a way as to facilitate openness with respondents about the purpose of the research and the use which would be made of it. To this end a reassurance was given to respondents that the findings were intended to be useful in making constructive comments on how good practice might be being impeded, and in making positive recommendations as to how practice might be improved. Practitioners were asked to 'participate' in the research: to be more than simply respondents, but to help the researcher through sharing the problem, identifying some of the difficulties, and thinking about the remedies. The health and education professionals could give their responses in the knowledge that they were not the main subject of the research - this position being held by the social worker - and yet they, and disabled children might benefit from the research findings.

The active participation of respondents can be engendered through the methodology of 'action-research'. This process is described as one which 'seeks to combine social research with social action' (Everitt et al 1992). This is achieved through a process of ongoing interaction between researcher, respondents and the commissioning agencies between whom the research aims and objectives are agreed and modified as findings emerge, and change-factors can be introduced during the progress of the study rather than once the research is complete. For such

research to be successful it requires respondents to go beyond being contributors or participants and to become more like co-researchers so that their ideas can lead to changes in the direction of the research. For example, Cohen (1996) undertook an action-research project to see how inter-professional practice in child protection could be improved. A local Family Health Committee, Social Services Department and Area Child Protection Committee jointly commissioned the project. The research methods she selected included uniprofessional and interprofessional focus groups, case studies, prescribed reading and interviews at the beginning and end of the study. The investigation examined the GPs' perspective with a focus on the key issues for them in fulfilling their role. Cohen's project is interesting for several reasons other than being a useful example of action-research and ethical research practice. Her study revealed GPs' attitudes towards social workers in child protection work, and demonstrated how these act as barriers to effective collaboration; and she provided some insight into the matters which lay behind these attitudes. Her research examined how problems could be addressed through 'learning opportunities'. The project bears some similarities with this study in that it focused on one profession while obtaining the observations of other practitioners involved, and hence Cohen's findings are worth examining in detail.

Cohen observed that GPs were on the periphery of child protection work and that they were uncertain as to what others expected of them. Facing high workloads and increasing demands GPs felt pressured to contribute to a child protection system for which they had insufficient time, experience, knowledge or training. Many GPs felt professionally and personally isolated: child protection work created clinical and ethical dilemmas for them which led them to respond with fear, guilt and a lack of confidence. Cohen identified practical problems in collaborative working: many GPs expressed frustrations over the difficulties they

had speaking directly with social workers. Cohen also highlighted how negative attitudes that GPs held about social workers acted as barriers to effective working. The source of these attitudes lay in the GPs' negative experiences of 'dealing with social services' and from their 'fears' about social workers taking precipitative action in child protection matters. Cohen also identified that the GPs' closer working relationships with health visitors arose in part from their more frequent liaison and personal contact; and she concluded that 'interprofessional trust' requires both effective joint-working practices and opportunities for formal and informal contact. Cohen also found that part of the action-research process, which entailed professionals reflecting together on case studies, enabled GPs to focus on issues of importance and to suggest how the barriers to effective collaboration could be overcome. The usefulness of this aspect of the research method is highlighted by the fact that groups continued to meet after the study was complete through the establishment of an interprofessional working party charged with the responsibility of taking their ideas forward. In concluding, Cohen recognised that because child protection constitutes only a small part of GPs' work and, therefore, because they are unable to dedicate much extra time to specific training, any instruction in this area needed to be predominantly interprofessional so that GPs could be 'exposed' to interprofessional collaboration at under-graduate and postgraduate level.

Although this study into collaborative working for disabled children was not undertaken through an action-research methodology it was influenced by the same principles. The researcher aimed to share the research problem with respondents in the hope that it would prompt their interest to pursue the subject further. In this vein it is pleasing to note that several respondents commented on how they had found the interview, or completing the questionnaire, to be an interesting and informative experience for them. This was not simply because the research

triggered their curiosity, but also because it seemed that they had not had sufficient opportunities previously to explore the issues surrounding interprofessional collaboration, or social work with disabled children, which the questioning raised for them. In this way perhaps the research served a positive purpose, as in action-research, regardless of ultimate findings. Interprofessional collaboration seemed to be a topical but neglected question as far as opportunities to discuss it were concerned, and therefore respondents' enthusiasm and interest appeared to underline the significance of research into this topic.

Similarly, Tope (1995) found that despite the perceived fundamental difficulties in conducting research into the interprofessional training initiatives of various professional bodies - that it would be seen as 'intrusive, implicitly critical and a threat to the autonomy of the profession under scrutiny' - in fact this did not hold true (1995:19). Tope found among the 13 health and social care professions which she surveyed that there was 'a willingness to push out frontiers and a genuine desire to learn with, and perhaps even more importantly, learn from each other' (1995:19). She found that the main consideration for all involved was how to enhance the quality of client care. Furthermore, in selecting an appropriate methodology for undertaking research into collaborative working, Tope concluded that 'if there is one phase that epitomises research into interdisciplinary learning, it must be 'shared ownership'. Each profession must be convinced that their contribution is positive and of equal validity' (1995:19)

The Client's View

In deciding on the appropriate sources from which to collect information for this research, consideration was also given to obtaining the views of disabled children and their families. Mayer and Timms' (1970) study entitled 'The Client Speaks' was the first research publication in

which clients' opinions were extensively used in evaluating the effectiveness of social work intervention. Since then considerable attention has been given to the perceived value of user-participation in social work research. Everitt et al (1992) have asserted that 'consulting consumers does provide knowledge for the effective development of services' (1992:121); and Morris (1997) has criticised researchers in the field of disability who have neglected to gain information directly from clients, and for restricting themselves to professional, managerial or political positions and opinions. Morris also criticised researchers for focusing on differences in children's needs due to disability, while not giving sufficient consideration to differences in gender, race, ethnicity, class and locality.

Morris (1997) identified that survey research regarding disabled children has tended to focus upon the views of their parents and carers. In fairness this approach is understandable, as the skills necessary for effective communication with disabled children often require significant practice experience. Marchant and Page (1992) acknowledge how difficult it can be for professionals to communicate with disabled children, particularly those with multiple disabilities or those who use unfamiliar methods of communication. However, Everitt et al (1992) assert that because social workers have skills in communicating with children and with disabled people they should be encouraged to undertake or assist in research and evaluation studies which directly seek children's views, instead of investigations focusing upon parents' interpretation of their children's views.

Nevertheless, the growth in social research involving the parents of disabled children is generally considered to have been a positive development, with Health Trusts and Local Authorities using research findings to plan and target their services more effectively, and to improve client satisfaction with service provision and quality. Storrie and Manthorpe (1997)

highlight how: 'the powerful image of the voice [of the service-user] has been used metaphorically to illustrate some of the recent major developments in health and social care' (1997:133). However, the involvement of users and carers offers a challenge to professionals, planners and researchers: Storrie and Manthorpe assert that the reforms introduced in the NHS and Community Care Act arose from critiques of past practice which contended that the system was driven by professional interests rather than service-users and carers, and hence that both choice and flexibility were restricted. They consider that involving service-users in local community care planning, as well as in their own individual assessments, increases their capacity to influence how services are provided through policy-making, resource allocation and service organisation. However, they observe that genuine partnerships have proved as difficult to achieve in this area as they have done in interprofessional collaboration, and hence that there are few examples to learn from. They point out that while the demand for interprofessional collaboration and user-participation grows there are abundant accounts of persistent failure. Thus it becomes crucial to question why this is, and to examine closely those strategies that have been successful in promoting user-participation at different levels of policy formation, resource distribution and service development.

In recognising the importance of service-users' contributions the researcher considered involving them in the survey for this study; however, the following matters influenced the decision against this course of action. The first consideration was that while the number of research projects and auditing schemes has grown and valuable insights have been gained concerning the needs of disabled children and their families within their own localities, an unfortunate downside has also emerged: families expect that the recommendations of research which asked their opinions would lead to positive and significant changes in services - they

anticipate practice improvements in the areas which they criticised, and they expect increased provision of the services which they identified as most helpful to them - and where this has not been achieved they have become disillusioned. It was noted earlier that Everitt et al (1992) identified how taking people's time and knowledge through research can amount to 'exploitation' if the outcome does not lead to an improvement in their conditions, or if they are not enabled at least to understand why this was not the outcome.

Within the locality of this study a number of research projects were undertaken during the early and mid 1990s by various agencies which asked for information from parents and carers. These included investigations by the Challenging Behaviour Service, the Family Support Team, the Barnardos Respite Care Scheme, the Echo Early Counselling Service and the County Council Audit Unit. In addition to these, the multi-agency Community Team for Learning Disabilities employed a Data Collector who recorded information about the assessed needs of clients, and gathered the views of parents and carers on the adequacy and quality of the services available. Furthermore, a Consumer Participation Officer encouraged parents and carers to contribute to, or participate in, local planning groups; and 'Parent Representatives' who attended planning forums also conducted small scale surveys of their own through interviews, postal-questionnaires, telephone canvassing and parent meetings. Marchant (1996), in reviewing research on users' views of services (for Northumberland County Council) similarly found what she referred to as 'an explosion of interest' in the views of parents of disabled children.

The researcher's observation as a practitioner during this period was that while many parents were pleased that their views were requested, they were nevertheless quite overwhelmed with the expectations upon them to get involved; they had enough demands upon their time and energy coping with their children's needs. The researcher's subsequent interviews with specialist

workers indicated that this situation had continued. Furthermore, parents were becoming cynical about the value of such research: they justifiably posed the question “Why do they ask us our opinions, and then take no notice?” Some parents felt that little was ever really gained, and that services were simply reorganised or renamed. While some parents recognised that progress had been made through some developments, such as the availability of more integrated and child-centred services, many of them felt that there was rarely any increase in the amount, or the choice, of services available to them. Furthermore, many parents felt that some very significant gaps in valued service provision continued, such as the family aide scheme; respite care for profoundly and multiply disabled children; social opportunities for school-aged children; sex education and counselling for adolescents; and day services for school leavers. Thus, because the water was muddied in this way by other surveys of clients’ opinions, the researcher decided not to seek directly the views of disabled children and their families. A further consideration was that while the researcher recognised the value of service-users’ views, it had been possible to establish through the literature review the importance with which parents and carers regard professionals’ responsibilities to work constructively with each other in meeting the comprehensive needs of disabled children.

4. Combining Research Methods

Examples were given above where researchers have effectively combined qualitative and quantitative methods in researching interprofessional collaboration. The following section will examine issues surrounding this approach and the advantages that it provides.

All researchers need to have confidence in the reliability of their findings because this has a significant effect on the validity of any conclusions reached. Thus the researcher needs to

ensure that the key research questions are identified; that suitable tools are selected for data collection; that an appropriate methodology is adopted; that the relevant respondents are selected; and that any other important matters have not been overlooked. For example, when testing out the effect of introducing change it may be useful to establish a 'control group' to serve as a benchmark for measuring the impact of the change-factors and in order to be sure that any differences identified were not brought about by any other influences. Furthermore, researchers need to guard against bias sampling or bias selection of responses, unless this has been explicitly undertaken for justifiable reasons. The rationale for these safeguards rests in the researcher's aim of achieving conclusions which are both valid and convincing.

Sieber (1973) observes that the use of two or more techniques for data collection and analysis, wherein the technical advantages of the different methods are capitalised upon, gives the researcher much greater confidence that their findings are reliable and valid, and consequently that their conclusions and recommendations should be taken seriously. Sieber remarks that 'The integration of research techniques within a single project opens up enormous opportunities for mutual advantages in each of three major phases - design, data collection and analysis' (1973:177).

Bryman (1988) considers that by closely examining the technical arguments for combining different research methods it becomes more evident how advantages can be captured from both quantitative and qualitative approaches, and how one approach can be used to reinforce the strengths of the other. However, Bryman draws attention to the epistemological perspective, which argues that the relationship between methods and the nature of knowledge is such that there are right and wrong ways of conducting research, and that the two 'traditions' of qualitative and quantitative methods reflect 'antagonistic views about how the social sciences

ought to be conducted' (1988:5). Bryman (1988) observes that this perspective is founded upon the view that research methods should gather data which reflect the subject's way of seeing the world. From this perspective, objections are most often made against the use of quantitative methods, the argument being that the researcher designs research tools to collect information on matters of interest to themselves, or to those who commission the research. Silverman (1985) counsels some caution in these respects, arguing that '...a researcher's *prior* definition of concepts and hypotheses *may* impose a meaning on social relations which fail to pay proper attention to participants' meanings' (1985:3; author's italics). However, Bryman (1988) advises that these objections can be overcome to some extent by the researcher providing evidence of how the subject areas selected for guiding the quantitative data collection were chosen through a considered process of identifying concepts and categories of most relevance to the respondents. He proposes that the researcher may be assisted in achieving this by becoming familiar with the research setting before the tools for gathering the data are designed, so that they establish an understanding of the respondent's environment and perspective. Bryman (1988) cites Sieber's (1973) observation that many survey researchers have an intensive knowledge of the locale, organisation, or whatever, which informs the formulation of problems to be investigated. Indeed Stacey (1969) considers that questionnaire techniques can only be used satisfactorily when the researcher already has a good knowledge concerning the subject. Bryman asserts that much can be gained by social science researchers if hard and fast distinctions between methods are avoided, and if a flexible approach is taken on how data can be collected and analysed. To this end, he observes that qualitative data can be derived from quantitative research methods and vice-versa, and that particular methods can be used simultaneously in collecting both quantitative and qualitative data. Bryman notes that researchers who combine methods rarely give equal

weight to them; usually relying on one method, which is associated with one of the research traditions, while supporting their findings with a method associated with the other tradition.

Burgess (1982) points out the value of integrating qualitative and quantitative methods when researchers are examining a fairly discrete social collectivity, for example, one school, one community or one department. However, he observes that, particularly in the USA, integrated research approaches have been adopted in investigating a large number of sites using a range of techniques: a cross site analysis is then made of the data, with the fruits of qualitative methods - observation, documentation, interviews, etc., - being integrated with those reaped from survey findings. Burgess considers that such an approach departs from the conventional use of qualitative research, in that the project is much more 'problem-focused' through the intention to investigate specific policy initiatives. Consequently a large degree of standardisation has to be in place to ensure that the same issues are addressed across the sites in comparable ways. Likewise, the data needs to be organised into comparable categories.

Such an approach raises the following interesting issues for this research study, and for research into interprofessional collaboration more generally. This study analyses the work of one profession, in one locality, through one service structure, yet the analysis is of the profession's practice within a multi-professional and multi-agency context, and previous research has shown how different professional groups in different agencies and environments have diverse attitudes towards each other depending on a wide range of influencing factors. Data for this research was, therefore, collected from a large number of sites i.e. different professional groups working in different agency structures. This study is also concerned with the impact of specific policy initiatives which require the promotion of interprofessional collaboration, yet these policies have different levels of significance and matters of relevance for the various professional groups.

Because of these differences, and because of the multi-faceted nature of the dynamics within collaborative working, it is most helpful and practicable for the aims of research in this field to be precise so that appropriate boundaries can be established. However, care has to be taken not to structure data collection tools too highly and thereby constrain the expression of interesting and useful issues and insights, or to lose the sense of how different factors at different levels - interagency, interprofessional and interpersonal - impact on collaborative working. Thus it is reasonable to restrict the scope of the research to specific investigations: such as the relations between specific professional groups (as in Wicks' (1998) study of doctors and nurses); or the effect of specific policy initiatives on particular professional groups (as in Lloyd, Webb and Singh's (1995) investigation into the impact of the Community Care reforms upon the relationship between GPs and social services personnel); or the perspective of one specific professional group in a distinct area of work (as in Cohen's (1996) research into GPs' views of collaborative working in child protection).

This research project is similar to that of Lloyd et al (1995) in that the scope was restricted to the study of the impressions made by one particular practice initiative (interprofessional collaboration), and to the examination of views about one specific profession (social work), within a distinct area of work (disabled children). It was given further boundaries through the decision to test-out specific barriers to collaborative working that had been identified by previous research as applying to all professional groups; therefore some mechanism for guiding areas of questioning, and for standardising responses was necessary. However, in order to avoid respondents being constrained from expressing matters of particular importance to them as individuals, or collectively as a professional group, the methods selected needed also to facilitate this expression - these needs were well met by combining qualitative and quantitative

methods. In this research the questionnaire was designed to cover issues of generic relevance to a range of professionals, while the interview schedule, by being semi-structured with some open-ended questions, allowed these issues to be explored in more detail and for differences to be expressed. In an effort to ensure that the questionnaire and interview schedule were adequately designed to fulfil these expectations the methods were further integrated through the piloting of the research tools. Several pilot interviews were conducted to inform the questionnaire design, and the questionnaire was then piloted. Once the data from the completed questionnaires had been analysed the information was used to inform modification of the interview schedule. In the presentation of the results it will be seen that data from the qualitative research largely supports the findings from the questionnaire, yet it also probes and reveals much more information regarding attitudes.

Thus the results give greater weight to the qualitative research tradition because, although the study collected quantifiable information about respondents' knowledge and views in specific areas, it particularly aimed to draw out respondents' attitudes. Having said this, there are no rules that state that social research must be based in one tradition or the other, or that boundaries must be placed upon the scope of any study, as Silverman (1985) points out:

We need not be either interpretivists or positivists, micro or macro analysts, or even qualitative or quantitative researchers...everything depends upon how the constituent elements are articulated (Silverman 1985:3).

Bryman (1988) proposes that combining qualitative and quantitative methods in examining the same problem is an example of 'triangulation'. This means that more than one research tool is considered necessary for measuring all the main variables within a study; and it is through combination that 'the researcher's claims for the validity of his or her conclusions are enhanced if they can be shown to provide mutual confirmation' (1988:131). This is not to say

that if mutual confirmation is not established that the findings are invalid - it may be so, but equally it could be that they present an interesting incongruence of findings, which is worthy of closer examination. In fact, Bryman goes on to note that 'it is in the spirit of the idea of triangulation that inconsistent results may emerge...' (1988:134). Stacey (1969) also advocates for triangulation, noting that one method can be used to 'check on the other', which can give confidence in mutually confirmed findings, and such checks can also be useful in countering bias.

Bryman (1988) observes another way in which the two traditions may be seen as usefully integrated in order to achieve a complete picture. He argues that 'quantitative research can establish regularities in social life, whilst qualitative evidence can allow the processes which link the variables identified to be revealed' (1988:142). From this perspective, quantitative research presents 'a static account' of phenomena, while qualitative research is useful in presenting a 'processual view'.

In this study the questionnaire was designed in part to gather data about the existing level of knowledge that other professionals have, or consider themselves to have, concerning aspects of social work. For example, respondents were asked to name the current professional social work qualification, to state the length and content of social work training, to indicate on a continuum whether they knew enough about social work training, and to comment on whether they considered social workers to be sufficiently trained. In this way the questionnaire generated quantifiable data about respondents' knowledge and opinions, and to some extent the source of it; however, the questionnaire did not provide insight into the various factors influencing their attitudes and opinions. The flexibility available through the interaction of researcher and respondent within the interviews allowed these matters to be discussed so that the factors

affecting their level of knowledge about social work training and their opinions about it could be explored; and in addition the attitudes behind their opinions could also be researched. It was indicated earlier that a further advantage of integrating methods is that while the questionnaire permits specific issues identified by the researcher to be tested-out, the interview allows the respondent's perspective on these issues to be heard, and gives them an opportunity to raise other issues which the researcher may have overlooked.

An advantage in combining methods, which is distinctive in the presentation of research findings, is that quantitative data can be used to set forth a general impression of the situation in the research area. This data can be used to counteract any potential criticism that the qualitative information either fails to provide a general view, or that bias has been used in selecting only those accounts that support the researcher's view.

Thus in summary, the debate surrounding the combining of research methods suggests that reliability and validity and hence confidence in research findings may be achieved through combining quantitative and qualitative research methods.

The self-completed questionnaire as a survey research method from the quantitative research tradition can be used to efficiently test-out previous research findings and newly-generated hypotheses, it may be particularly valuable when skilfully designed by a researcher with extensive knowledge into the field under investigation. It is a useful tool for obtaining information about the respondent's present position on specific issues.

The semi-structured interview schedule, with some open-ended questions, as a survey research method from the qualitative tradition can be used to gain leverage on, and insight into matters not usually accessible through questionnaire survey, such as attitudes and the process

behind the formulation of knowledge and opinions. It is particularly useful in allowing the respondent's own perspective to be heard.

Combining methods can help the researcher to gather as full an account as possible of the phenomena under investigation. Any weaknesses or inefficiencies that might arise from using just one method may be overcome by utilising the inherent strengths of each method and by crosschecking across techniques. Combining methods may also reveal inconsistencies worthy of further research. Validity for the conclusions may be claimed confidently by referring to examples where the findings can be confirmed across different methods. A comprehensive knowledge of the field under investigation, allied to attentive design of the research tools can help overcome any epistemological arguments that particular methods are only suitable for collecting particular data.

5. Design Procedures and Data Collection

This section describes how the research tools were developed through a process of design, piloting, evaluation and modification.

The design procedure began with a draft interview schedule constructed for health and education professionals. The schedule collected some basic information about the respondent and then enquired into their role with disabled children, their experiences of collaboration with social workers, their knowledge of social work and how any expectations they might have developed of the profession compared with their experiences in practice. Specific enquiry was also made into their observations of barriers to effective collaboration, and how these might be resolved. The interview schedule was piloted with four experienced professionals:

A Registered Nurse (Mental Handicap) with ten years' post qualifying experience, working in a hospital-based Residential Unit (Learning Disability) providing respite care and a challenging behaviour intervention service.

A Play Therapist with four years' post-qualifying experience, working in a hospital-based multidisciplinary Child and Family Consultancy Service (Child and Family Guidance).

A Health Visitor (Midwife and Registered Nurse) with fifteen years' experience, working in a busy town centre GP practice.

A Specialist Teacher with twenty-five years' teaching experience, working in a hospital-based multidisciplinary team for disabled children.

These people were selected because they represented the range of professionals intended for survey and because of their relevant experience. Plenty of time was made available for these interviews so that the respondents could discuss the research problem in detail. The interviews were audiotaped and transcripts were analysed. This was valuable in identifying any significant themes at an early stage. The initial findings from these interviews were then used to modify the schedule in order to make it more focused. The modifications made were more a matter of emphasis and time spent on particular questions rather than the introduction of any new questions. For example, the researcher found that it was necessary to limit the amount of time spent in the rapport stage discussing the respondent's own professional experience as this consumed valuable time which needed to be more focused on their experiences of social work.

The resultant schedule, along with the data collected from the pilot, was then used to inform the questionnaire design. The difficulties of designing a questionnaire became apparent at that time and the researcher's expectations of what data could be collected had to be modified. Several drafts were made and piloted by patient colleagues. After each pilot the questionnaire

needed to be simplified both to reduce completion time, and to lessen the scope for confusion within some of the questions. The final questionnaire was a far simpler tool than the first drafts. Designing it allowed the researcher to realise how limiting the use of self-completed questionnaires can be for collecting data on issues requiring insight into attitudes. This process also enabled the researcher to appreciate the advantages of the interview for gaining in-depth information, and the strengths in combining qualitative and quantitative methods in collecting both a range and depth of data.

In designing the survey the researcher needed to be mindful of how respondents might interpret the terminology used within the questionnaire and interview schedules. Individuals and agencies use a range of different expressions to describe the nature, level and type of a child's impairment. It was important, therefore, to consider ways of avoiding confusion for respondents over which children the research was concerned with (Morris 1997). Often people refer to degrees of severity of children's impairments. For example, The Joseph Rowntree Foundation (1994) refers to 'severely disabled children' as distinct from children whose impairments are less severe, who they describe as 'having special needs'. Others reserve the expression 'disabled' to denote only those with severe impairments. Some do not refer to children who solely have intellectual impairments as disabled at all, instead they refer to them as 'children with learning difficulties', and reserve the term disabled for children with physical or specific sensory impairments. Others prefer to use the term 'special needs' to encompass children with various impairments regardless of the level of severity, and including children with psychological or behavioural difficulties (e.g. Warnock 1978). Some agencies use a range of different terms to describe disabled children. For example, in 1991 the Welsh Office (1991) employed the following groupings: children with physical disabilities, including those permanently disabled by

illness; children with learning disabilities; and children with visual or hearing impairments (sensory impairments).

To minimise potential confusion for survey respondents, the researcher deliberately interchanged the use of terms in current usage among practitioners, while introducing questioning with a more precise explanation of which children were the subjects of the enquiry. The phrase 'children with special needs' seemed most appropriate to the focus of the research. This expression held advantages in that it could counter any tendency among respondents to limit their thinking and responses to just those severely disabled children whom they knew, and about whom they might collaborate with specialist workers. The term encouraged respondents to think also of those children with less severe impairments with whom they had contact, including those with psychological and behavioural difficulties.

Accordingly the introductory remarks of the questionnaire referred to 'children with special needs'. In the questionnaire the term was interchanged with 'children with disabilities' - essentially because this was the language of the Children Act 1989 and its guidance. The questionnaire was discussed with service managers prior to distribution, and with groups of health visitors at their team meetings, with an explanation being given about which children the enquiry was concerned with. Likewise, in introducing the interview schedule respondents were informed that the enquiry was not only concerned with collaborative working for disabled children with conditions such as Down's syndrome, autism or cerebral palsy, who would be known to specialist workers and would probably be attending special school, but that information was also required concerning their work with children who have less severe impairments, or who have significant behavioural challenges (such as those with attention deficit hyperactivity

disorder), who might not be known to specialist services, and who might be attending mainstream school.

Once the researcher was finally satisfied that the questionnaire and interview schedule would reap the information required and that they were practicable tools, they were used for gathering data from a range of health and education professionals. The questionnaire was used to gain quantitative data, which could be statistically analysed, and the interview was used to obtain qualitative data by exploring the same issues in depth, allowing for broader exploration of any interesting issues arising as relevant to any particular professional group or individual.

The Questionnaire¹

The questionnaire was divided into four main sections, asking thirty questions about:

- A: The respondent, their role and the organisation of their work.
- B: Their collaboration with social workers.
- C: Their knowledge and views about social work.
- D: Their views on effective collaboration.

The Interview Schedule²

The interview schedule was designed to gather data that would be comparable with data from the questionnaires and so that responses could similarly be coded. As well as examining the same issues as the questionnaire, the interviews explored specific matters in five further areas.

These were as follows:

¹ See Appendix 3

² See Appendix 1

1. Differentiation in roles and skills. While both the interview and questionnaire respondents were asked to state the tasks that they undertake in their role for disabled children, interview respondents were also encouraged to explain what they considered to be particular to their profession. If their response suggested some role overlap with social work, they were asked how they differentiated their role from that of the social worker. This line of questioning allowed the researcher to hear their views on the type and level of skills they expected from social workers in common areas.
2. The quality of social work collaboration. While the questionnaire asked respondents to indicate how frequently they had liaison with social workers over specific tasks, further enquiries were made with interview respondents about the quality of liaison and collaboration with social workers.
3. Social work skills with disabled children. The questionnaire asked respondents to state the areas of knowledge and skills which they considered to be essential for social workers in providing services to disabled children, and they were asked to indicate whether they found social workers making a sufficient contribution in these areas. In the interview, respondents were asked more specifically for their opinions on social work skills in the field of special needs and social workers' knowledge about childhood disabilities. They were also asked whether they found social workers were explicit about the theories and values that informed their work.
4. A 'unique' contribution and the 'ideal' social worker. While the questionnaire asked respondents whether they considered social workers to have any unique contributions to make, the same question was asked in the interview and the issue was explored further by requesting respondents to describe what an 'ideal' social worker would be like.

5. The care plan co-ordinator role. The questionnaire asked if respondents had received training about recent legislation that applied to disabled children. The more specific matter concerning professionals' views about social workers co-ordinating everyone else's contribution to the child's plan, in the manner proposed by legislation, was explored in the interviews.

An interview schedule was also designing for social workers (see Appendix 2). The researcher considered it useful to ask social workers the same questions to explore the same issues from the social work perspective. Issues arising from the initial analysis of the survey of other professionals suggested some further lines of enquiry for the social workers.

Social workers' views were sought concerning whether only specialists should work with disabled children. This line of enquiry arose because other professionals' more positive opinions of social workers reflected, in the main, their experiences of specialist social work activity in the locality rather than generic workers. .

6. The Selection of Respondents

In selecting respondents, consideration was given to the most significant health, education and multi-agency services with provisions for disabled children operating in the locality. These included:

1. a multidisciplinary and multi-agency team for children with severe learning disabilities, with a health visitor, community nurse, teacher, occupational therapist and a social worker as members;
2. hospital-based services, including paediatric services

3. a multidisciplinary and multi-agency Child Development Team, led by a consultant community paediatrician;
4. a multidisciplinary Child and Family Consultancy Service (Child Guidance);
5. the schools and Education Psychology Service;
6. community health services, including health visiting, occupational therapy, physiotherapy, speech therapy and a challenging behaviour service.

The researcher decided that interviews with twenty health and education professionals practising in these services would be a feasible objective, bearing in mind the limitations on the study mentioned in section 1. These respondents were from a total of approximately 65 professionals within the locality. The sample included most of the non-social work practitioners involved in the first three services above (8). A smaller sample was selected from child guidance, education and community health services because of the more generic nature of their work with children. The researcher considered that 12 respondents across these services would provide a representative sample and that questionnaires distributed to other practitioners in these services would give a more general perspective. The selection of respondents for interview and questionnaire are discussed below in more detail. All these respondents had contact with social workers: some within their nuclear teams, some within extended teams, and others through interprofessional collaboration across service and agency boundaries.

Health Visitors

The largest group was health visitors, all of whom had disabled children on their caseload. Most health visitors aim to increase the frequency of their visiting to disabled children and their families in order to offer advice and support, or to provide guidance about the child's

developmental needs. They are key professionals for families in the early stages of identification of a child's special needs, from developmental delay and behavioural challenges through to more severe disabilities. The research aim was to obtain data from all the health visitors in the locality (a total of approximately 55). Six health visitors were interviewed. These were selected because of the locality of their work: three serving the main county town, and three the more rural areas. Questionnaires were distributed to all other health visitors and 33 were completed.

Paediatricians

Paediatricians play a very significant role in the diagnosis and on-going medical treatment of childhood disabilities; hence they are crucial in advising parents, carers and their families about the services available from other professionals and their agencies. Furthermore the Community Paediatrician chairs and co-ordinates the Child Development Team for disabled children. Because of their important and pivotal role all three consultants working in the locality were interviewed.

Learning Disability Team

Members of this multidisciplinary team offer services to families who have children with severe learning disabilities. Team members carry a caseload of families for whom they act as 'key workers' with some responsibility for co-ordinating service input. In addition, the health visitor provides advice and support and a 'Portage' service for pre-school children with significant developmental delay; the community nurse specialises in direct work with teenagers with severe learning disabilities and their families; the teacher is available to parents for advice on educational matters and the occupational therapist has a remit to provide services to children

with physical and sensory impairments. There is a specialist social worker in the team, and both a paediatric physiotherapist and a paediatric social worker are closely linked with the team as 'extended' team members. All these practitioners are also key members of the Child Development Team. Because of their dedicated and specialist roles with disabled children they were all interviewed.

Education Services

Teachers play a very significant role in the lives of disabled children. They have frequent and important contact with most parents and carers and are therefore in a key position to act as a source of information for them regarding other services. Five special needs teachers were interviewed from a total of 12, who were working within the five schools providing special education services for disabled children in the locality. Two teachers were interviewed from one special needs primary school unit. Three teachers were interviewed from two of the three special needs secondary school facilities. A further four teachers completed the questionnaire. One educational psychologist who had frequent contact with disabled children through the special schools was interviewed and another one completed a questionnaire. This was from a total of three educational psychologists with responsibilities in the locality.

Social Work Respondents

Interviews were also conducted with ten social workers: eight from the child care teams and one each from paediatrics and learning disability services. The survey of social workers was restricted to those employed by the local authority social services department. Although other qualified social workers are employed to work in services in the locality they were not included

in the survey for two reasons. Firstly, because of the specificity of their role within, for example, family placement, child protection and youth justice work. Secondly, the main focus of the study is concerned with other professionals’ attitudes and expectations of social work intervention and collaboration for *all* disabled children regardless of the nature or severity of the child’s physical or intellectual impairment. Child care social workers make up the ‘front-line’ and child care teams serve as the starting-point for mainstream integrated children’s services from which referrals to more specialist services are made if necessary. It was therefore from these social workers that the research information was required. However, the contributions of the paediatric and learning disability social workers were also crucial because they provide a community service to disabled children within the same locality as the child care teams; and they can provide specialist advice to the child care workers. A representative sample was selected from the two child care teams by interviewing four out of the seven social workers in each team.

Overview of Respondents

The following tables provide details of the total number and percentage of survey responses by profession. This is followed by a discussion of how the field work was conducted.

Table 8.1 Number and percentage of questionnaires completed by profession

Questionnaires Completed By	%
33 Health Visitors	83
4 Teachers	10
1 Speech Therapist	2
2 Psychologists	5
40 Total	100 %

Table 8.2 Number and percentage of interviews conducted by profession

Interviews Conducted With	%
6 Health Visitors	26
6 Teachers	26
3 Paediatricians	13
2 Speech Therapists	9
2 Community Nurses	9
1 Paediatric Physiotherapist	4
1 Art Therapist	4
1 Paediatric Occupational Therapist	4
1 Educational Psychologist	4
40 Total	100%

Table 8.3 Number and percentage of survey respondents by profession

Total Respondents	%
39 Health Visitors	61
10 Teachers	26
3 Paediatricians	5
3 Speech Therapists	5
3 Psychologists	5
2 Community Nurses	3
1 Paediatric Physiotherapist	2
1 Art Therapist	2
1 Paediatric Occupational Therapist	2
63 Total	100

Linking professionals because of commonalties in their training, or employment shows that nursing professionals made up 65% of all respondents.

Table 8.4 Number and percentage of survey respondents by professional training and/or employment

Total Respondents	%
41 Nurses	65
10 Teachers	15
6 Therapists	10
3 Doctors	5
3 Psychologists	5
63 Total	100

Interviews

The researcher first sought agreement for interviews to be conducted from service managers. This was done through direct approaches and formalised in writing. Direct approaches were then made to selected respondents in person or by telephone to request their assistance. Most interviews were conducted at the respondent's workplace unless it was more convenient for them to be seen elsewhere.

Written notes were taken instead of recording the interviews. This decision was taken in consideration of two issues. The first was that in the initial interviews several respondents disliked being recorded. In one interview the respondent asked for the recorder to be switched off before expressing a particular view about social work. Rather than dispense with the tape recorder for those respondents who positively stated their disquiet, the researcher decided to

abandon its use altogether so that none of the respondents would feel restricted in their discussions. The second consideration was a practical one concerning the volume of work which transcribing taped interviews created. Because of the limitations upon the researcher's time the decision was made to take notes during the interviews and to reserve time after the interviews for more detailed note-taking and reflection on the views expressed.

The Questionnaire

Questionnaires were distributed to obtain quantitative data from health visitors, special needs teachers, speech therapists and psychologists. The majority of questionnaire respondents were health visitors. In an effort to achieve a high response and in order to share the research problem with respondents, the researcher attended two health visitors' locality meetings, with a view to their completing the questionnaires at the meeting. However, because of limited time at one of the meetings it was necessary for respondents to take the questionnaire away. The consequence of this was that several were not returned. However, those that were returned were comprehensively completed. At the other locality meeting all the questionnaires were completed, though many questions were less comprehensively answered.

Regarding teachers, the head teachers distributed questionnaires and those who were qualified and working in special schools or special units for disabled children attached to mainstream schools were requested to complete them.

A low response was received from speech therapists, with only one of the six completing a questionnaire. However, two members of this profession were interviewed, thus ensuring sufficient representation.

Although all four members of the Challenging Behaviour Service completed questionnaires only two were qualified (both psychologists), the other two were unqualified support workers. Consequently, because these latter two respondents were not professionally qualified they have not been included in the analysis.

Summary and Conclusion

This chapter has defined the purpose and scope of the investigation and explained how disabled children formed the focal concern of the study. It has identified social workers as the main subjects of the research and other professionals as the primary source of information. The chapter has explored the suitability of different research methods and methodologies for studying collaborative working and considered the limitations, ethical issues and other factors that might affect this study. This discussion highlighted the importance of selecting respondents to ensure that they would be representative of their role and profession. The discussion also identified the need for careful design of the research tools and methodology so that questioning could be effectively targeted and guided while also facilitating respondents' motivation to participate in the research and to be open in expressing their views.

The chapter discusses how the researcher concluded from literature about research that the combination of qualitative and quantitative methods for data collection and analysis could be most suitable for this study. The evidence was presented that such a combination could permit advantages to be taken from different methods, for the strengths of one method to reinforce the other, and for greater confidence to be achieved in the reliability and validity of the findings. This discussion identified the questionnaire and interview schedule as appropriate tools for the

study; and evidence was examined of how these tools had been used effectively in a range of other investigations concerning collaborative working with social workers.

The chapter considered arguments in favour of adopting an approach to research that allows the problem to be shared with respondents. Evidence was discussed of how semi-structured interviews could facilitate an ethically sound research method, which might also elicit openness from respondents concerning matters of particular importance to them regarding the research problem. The chapter also considered the argument that, with some caution, the questionnaire and interview schedule could permit valuable use to be made of the researcher's own insights and experiences of the problem and the locality in designing the research and methodology.

This chapter has explained the procedures followed in designing the data tools and in identifying the specific areas for exploration with respondents through the interviews and questionnaires. It has also discussed how the respondents were selected and how the field research was actually conducted. The following chapters complete the thesis by presenting an analysis of the findings.

Chapter 7

The Social Work Perspective: Statement of Results – Part 1

Introduction

The literature review has shown how difficulties in collaborative working may arise for social workers because relationships between different occupational groups are affected by the credibility or otherwise that they give to each other's claims to possess knowledge and skills relevant for practice, at a level considered appropriate for a 'professional'.

The review has also shown how the success of social work's claims to have appropriate knowledge and skills for working in the care of disabled children and families may have been discredited somewhat because of the profession's inconsistent practice in this field of work. Moreover, social work's claims to professional training appears also to have been discredited, because the preparation of social workers for practice in this field has been judged inadequate over many years.

The sources cited in this thesis have provided information about the manner with which professional roles are socially constructed, how different work is thought suited to different occupational roles and how, as a consequence, competence tends to be matched to particular professions. The implication of this for social work, in the light of inconsistencies in practice and inadequate training, is that their practitioners may be viewed as less 'competent' and 'professional' than others for work with disabled children.

Nevertheless, the literature has revealed that different workers have important and distinct roles to fulfil in child disability work, each of which require their particular knowledge and skills. Moreover, the social work role has increased in relevance over recent decades as service

provision has shifted away from institutional models of care to supporting disabled children at home and in their communities. However, partly because of history and tradition, the medical profession continue to command a high level of authority and leadership in this field of work. The literature suggests that other professionals generally accept this medical authority and, in doing so, also tend to work within the doctor's framework for practice - a framework based essentially on a 'medical' model of disability. Considering these matters, beside the identified practice weaknesses and training inadequacies, this thesis suggests that social work's claims to be best qualified to assume a leading role in facilitating collaborative working in this field of work can be met with a substantial degree of disbelief, if not resistance. Thus, social workers face a double challenge in their efforts to achieve effective collaborative relationships based on others' recognition of their professionalism. First, to prove their competence and the value of their contribution and second, to promote the social model of disability (and associated principles) as a more appropriate framework within which to consider the needs of, and arrange services for, disabled children and families.

The theories of collaboration discussed in Chapter 2, and the discussion of integrated service structures in Chapter 3, have demonstrated that for social workers to manage this challenge, and thereby to overcome collaborative difficulties and practice weaknesses, support from their agencies in achieving these objectives is crucial.

The discussions in this chapter are informed by social workers' own opinions about interprofessional collaboration and practice in child disability work. The interviews gave social workers an opportunity to explain their interpretations of why collaborative difficulties and practice weaknesses come about and how they might be overcome.

The survey findings have particular value because the respondents provide their opinions based on the reality of what their training and experience has given them in the way of understanding collaborative working and practice in child disability work. Their insights concerning social work and collaborative relationships are not simply intuitive or based on gut-feelings, they are informed by this personal history of their training and practice experience. Their opinions, and the strength of feeling that they express about the issues discussed, provide insights that are available from no other source. Their contribution to understanding the phenomena of difficulties in collaborative working is drawn from their experience of being on the front-line - that is, it is drawn from experience of practice in the field, which is characterised by all the realities of their working lives. These are not the views of managers or consultants, of academics or trainers. These are the views of those who experience what it is to be a social worker and to collaborate with teachers and doctors, health visitors and therapists in their day-to-day work in the care of disabled children.

The discussion focuses on what respondents' views reveal about the researcher's thesis concerning the social work potential to overcome practice weaknesses and collaborative difficulties. The findings also provide further insight into the reasons for the disparity between the rhetoric surrounding the social work role and the reality of what social workers can realistically achieve in the field. Throughout the chapter social workers' comments are interpreted and certain issues are drawn together for discussion under sub-headings. These include a discussion about some social workers' apparent avoidance of child disability work, and some discourse concerning particular factors that affect the competence with which social workers can fulfil their role. These are the researcher's interpretations, which are based essentially on the understandings gained from sources identified in the literature review. These

interpretations are made with the consideration in mind that there is a difference between what respondents tell the researcher and what may be evident 'between the lines' - that is, they are inferred from the respondents' comments and practice examples.

After some discussion about the survey sample, the findings are presented in three sections. The first considers social workers' thoughts about their role with disabled children and their relationships with other professionals in fulfilling the role. Their views are also explored concerning that which they consider distinctive about how they help clients. Respondents were asked to describe their 'ideal' of social work practice in order to encourage discussion about that which they perceive to characterise, aid or impede good practice with disabled children and families. Some of the problems that social workers experience in carrying out their role are then discussed and compared with the 'ideal' role. The discussion also explores social workers' opinions about how changes in legislation and policy have had an impact on their practice.

The second section discusses social workers' practice in collaborative working. Their experiences of difficulties in collaborative relationships are explored, along with their perceptions of what causes these difficulties and how they might be resolved. The questioning aimed to elicit respondents' views about what individuals, professions and agencies could do to achieve effective collaboration.

The third section considers social workers' views on their training. The discussions in Chapter 5 revealed the importance of a continuum of education and training in providing social workers with opportunities to develop theory and methods of intervention that enable them to practice efficiently and effectively. The purpose of questioning was to discover whether social workers considered that their training had equipped them adequately with the knowledge and skills required to facilitate collaboration and to help disabled children and families.

The Respondents

All ten social workers interviewed might fairly be described as specialists because they were employed specifically in child care social work. However, two respondents had a remit to work only with disabled children whereas the other eight worked in child care teams. All the social workers could carry case responsibility for disabled children. Both the specialist social workers had caseloads dedicated to disabled children, some of whom were in foster placements or with adoptive families. Many of these children also had periods in respite care, some with short-term foster families arranged through a voluntary sector organisation and some in the social services respite homes.

The eight child care social workers had caseloads that included children assessed as 'children in need' under Section 17 of the Children Act 1989. The bulk of their caseloads included children in accommodation, children for whom the local authority had legal responsibility through care or supervision orders, and children whose names had been placed on the child protection register. All of these workers considered that this casework involved them in providing social work services to children whom they described as having 'special needs'. This phrase encompassed children with intellectual, emotional or behavioural needs that arose from adverse circumstances in childhood, as well as those with congenital disabilities. At the time of the survey, six of the child care social workers had responsibility for disabled children with either significant learning disabilities or behavioural difficulties. These children were educationally assessed at level three, four or five of the statementing procedure - that is, they required additional help in school and input from the educational psychologist. Social workers reported that these children, and others with similar needs, could be referred to them either because there

were child protection concerns, or because there were accommodation issues, such as the child being in foster care or placed with extended family under local authority agreement.

Nine of the respondents were qualified with CQSW and one more recently with the DipSW. The ten respondents had on average 12 years' post qualification experience; five of them had fifteen or more years in practice. All the respondents had social work experience in different forms before qualifying. None of the child care social workers had been employed in social work specifically with disabled children or adults before or since qualifying. However, several of them had gained relevant experience before qualifying or as part of their generic work. For example, one respondent had done voluntary work at a social club for adults with learning disabilities, three respondents had worked in residential child care with children with 'special needs', and one respondent had extensive experience in fostering and adoption, which had included disabled children, and she had also undertaken a placement with adults with learning disabilities. Neither of the two specialist social workers had particular experience of disabled children before their appointments to the specialism; their experience was gained solely from generic casework. However, their interest developed from that casework, and led them further down the path of specialisation when the opportunity arose. The experience of these social workers seems quite considerable. However, they were selected at random from the pool of qualified staff working in children's services across the authority. Random selection was employed to ensure that the research sample would be representative of the general experience in the authority. Unfortunately, information is not available to compare their level of experience with social workers in this field of work across the country as a whole.

The opinions that unfold within this chapter reveal markedly diverse views among respondents about the social work role with disabled children. However, with only a small

sample it was difficult to identify the reasons for this. The contrasts may reflect differences in their training, or practice experience, or the impact of changes in philosophy in child disability work. However, none of these stood out as particularly likely to account for the differences. One tentative explanation is that when respondents' interest in child disability work was combined with their experience of disabled children and families it appeared to give them a broader perception of the social work role - that is, a perception arising as much from their experience as from training or professional identity. While this was only a small sample of social work respondents it revealed a wide range of illuminating responses. However, any generalisations from the survey are made with the limitations of the sample in mind.

Section One: The Social Worker's Role and Particular Contribution

This section considers respondents' practice in social work for children and families. The discussion provides information about the context within which child care social workers respond to referrals of disabled children and families. This is helpful for understanding what the respondents perceive as their primary responsibilities when referrals are made, and how they develop their understanding of the social work role with disabled children and families. The section then explores social workers' views about what distinguishes their work with disabled children and families from that of other professionals.

The discussion that follows considers respondents' thoughts about what a social worker would do for disabled children and families if circumstances were 'ideal'. This is helpful in identifying the problems that they perceive to restrict them from carrying out their role comprehensively. Finally, the section considers respondents' views on whether their practice with disabled children and families has been aided or impeded in recent years by changes in legislation or local restructuring.

The Social Work Role

Most child care social workers described their work as 'task-centred' or dealing with 'presenting problems'. Their starting point for intervention in nearly every case was at least a serious, urgent or demanding need, where the family might have already reached a crisis point and were desperate for help. Alternatively, intervention was in response to concerns that the child may be at risk of significant harm. Social work intervention followed a continuum from dealing with the 'presenting problem' at one end (requiring short-term involvement) through 'crisis intervention' at the centre of the continuum (requiring short to medium-term involvement,

wherein the social worker provides emotional support, and acts as an advocate for the child and family) to the other end of the continuum which is 'Child Protection' (requiring a 'keyworker' role to be fulfilled wherein all the preceding tasks are undertaken and the planned intervention of other professionals is co-ordinated).

The difference between the child care social workers and the specialist social workers was that the latter saw the tasks of keyworker as central to their role and way of working, without the element of child protection being required for intervention.

Respondents considered that other professionals agreed to their keyworker role for disabled children for two reasons. Child care social workers gained agreement from their 'mandate' to intervene to protect children from abuse or neglect, and from their statutory responsibility to co-ordinate and monitor the progress of plans for children on the child protection register. Specialist social workers gained agreement because other professionals recognised their specialist skills; these workers considered their membership of a multidisciplinary team significant in achieving this recognition.

The following discussion considers the social workers' views about their role for disabled children, and the collaborative difficulties affecting its fulfilment at different points along the aforementioned 'presenting problem' - 'crisis' - 'child protection' continuum. The discussion has been organised in this way to draw out social workers' own distinctions in their reasons for involvement with disabled children. These reasons also provide an indication of the criteria by which disabled children and families receive their services. However, the discussion is not rigidly organised within the structure of this continuum because, as the examples demonstrate, reasons for intervention often overlap - for instance, a social worker may deal with a presenting problem and/or arrange a service for a disabled child who is known to them because of child

protection concerns. Opportunities are taken to develop particular issues during these discussions, and to consider what respondents' comments suggest in relation to the thesis that they have the potential to overcome practice weaknesses and collaborative difficulties.

The Presenting Problem: Assessing Need for Services

All the social workers considered that their role in obtaining services for families was very important. Several child care social workers suggested that this was their key role, while the specialist social workers viewed it as just one part of a much broader role.

Some child care social workers perceived there to be a wider role than just arranging a service, which included co-ordinating services over the long-term. However, most respondents expressed unhappiness that other work demands limited their involvement to short term intervention as required to meet families' immediate needs. All the social workers expressed dissatisfaction with the lack of services and resources available for them to offer families in need. These were recurring themes throughout the interviews, and so they are discussed in detail later in the chapter.

Mrs D, a recently qualified child care social worker, described her role with disabled children as 'task-oriented'. She explained this as meaning that she would meet families to find out how she might best assist them with the specific problem for which they were referred, but nothing more. For example, arranging foster care for a family referred for respite. Mrs D considered that her particular professional contribution for disabled children and families lay in securing the services of the Social Services Department.

On the face of it Mrs D's comments suggest that she understood her role quite simply as fulfilling the function of arranging practical services for families. Her remarks suggest a limited

view of the social work role, which might be accounted for by her lack of experience in field work since qualifying. However, Mrs D also expressed disillusionment about what her department had to offer in the way of practical support for disabled children and families, so this may explain to some extent her limited view of the social work role. She remarked that the range of child care services available was poor and often inappropriate for disabled children. She could not conceive of improvement without more substantial investment of resources by the agency. Mrs D based her criticism on experience of working in another authority where many more suitable services were available.

The contribution to understanding that this makes is in demonstrating how social workers may narrow their perspective of their role and what is possible to achieve for families if the reality of what they are able to offer in a given locality is limited by insufficient practical resources.

Mrs D also considered that the inadequacy of services adversely affected her relationship with other professionals. She commented that ‘They expect that this is what social workers are there for, so they are unimpressed by the social worker who does not provide a range of practical services.’ She presented an example of a health visitor who ‘sent’ the mother of a child with night-time enuresis to the child care team to ask for help obtaining a new bed. Mrs D was not able to provide this assistance. This disappointed the family and the health visitor, and Mrs D concluded that it reflecting badly on her.

Other than the effect on the social worker’s collaborative relationship with the health visitor, Mrs D’s example highlights several other issues concerning collaboration and the social work role. First, it is striking that the health visitor suggested that the parent should go directly to the social work office without first discussing it with the social worker. This suggests that the

health visitor views the social worker as carrying a somewhat limited ‘handmaiden’ role: a role in responding to needs that have been assessed by her. Several respondents mentioned this experience of social workers being perceived simply as resource procurers, so it is discussed with further examples later in the chapter. Second, Mrs D’s perception that her inability to provide the service would damage her relationship with the health visitor suggests a lack of confidence in her wider skills, and perhaps a degree of acceptance of the ‘handmaiden’ role. The lack of confidence among the child care social workers was also a recurring theme, and it is discussed at several points in this chapter. Third, it was mentioned above how Mrs D’s comments suggest a limited understanding of the social work role - this may have restricted her from exploring alternative avenues for assisting the family. Finally, the agency’s unwillingness to provide the finance for an inexpensive resource was perceived by the social worker as impeding her in fulfilling her role and in collaborative working. This perception that their agency fails, in various ways, to support them adequately in their work with disabled children and families was referred to by most of the respondents as creating barriers to more effective practice.

In similar vein to Mrs D’s comments, another child care social worker, Mrs C, described her role as a ‘provider and facilitator of local authority services.’ However, despite ten years of post qualification experience in children’s services, Mrs C added the proviso that ‘I can’t do much.’

She explained that child protection constituted the main reason for her involvement with disabled children. She considered that she had little else to offer than her skills in monitoring the child’s safety.

I have never had any disability training, so I don’t know what to do... I know how to protect, I know how to prepare a package of services, and I know how to pull in other professionals. (Mrs C.)

More broadly, if needs arose that required intervention other than those she mentioned, Mrs C declared ‘Oh my God, I don’t know what to do - call the specialist social worker!’

Mrs C considered that ‘In reality my role in child care entails child protection and managing very difficult cases.’ However, she thought that her caseload was skewed this way because of her experience. She thought that other ‘less experienced’ social workers might have more children with special needs on their caseload.

Mrs C’s comments suggest that there was no capacity for disabled children on her caseload, or that of other experienced child care social workers, unless the reason for referral was child protection. She thought that some children with ‘special needs’ were known to other team members where the work was less demanding and required less experience than child protection. However, this was not supported by the accounts of other social workers interviewed. It seemed that generally social work practice was that disabled children were only on any worker’s caseload if the referral fell somewhere within the continuum described at the start of this section, and only for any length of time if there were child protection concerns. Mrs C’s caseload may, therefore, have been skewed away from disabled children either because her skills were required for other high risk cases that did not involve disabled children, or because she had not demonstrated skills and interest in child disability work. The latter reason seemed more likely as Mrs C’s comments suggested that she judged herself ill-equipped to transfer her knowledge and skills from generic child care social work to work with disabled children. She considered that extra training would be essential to her achievement of this. Thus, despite ten years of experience, where disabled children were concerned she reduced her role, like Mrs C, to that of an agency functionary who arranges services as requested.

On the face of it this suggests a striking lack of confidence. Although, it might also indicate - as Middleton (1996) had found - an avoidance of disabled children based on a somewhat contradictory perception that disabled children either require the skills of a specialist, or that their 'special needs' can be addressed by less experienced social workers. This issue of avoidance is discussed further below in the context of other examples.

In contrast, the comments of Miss G, a very experienced social worker, demonstrate a perception of a much broader role in helping families with disabled children to access services. Miss G considered it her responsibility to find out what services might be available - 'to discover who does what, where and why' - and to advocate for the family in obtaining the services they required, while providing them also with some emotional support. Another very experienced child care social worker, Miss B, also described her role in similar terms. However, both these respondents expressed unhappiness at not having enough time to support families as they would wish, or to explore alternative solutions to their particular problems.

Miss B explained why she thought this was: 'Disabled children are a 'low priority' on the child care team's caseload.' In practice, this meant that social workers responded only to the 'presenting problem' for disabled children; they did not really have time to consider any wider perspective. Miss B gave an example of a referral she had dealt with where the request was for some respite. She remarked that 'this will be sorted out if possible, but nothing more.' Miss B considered that ideally she would want to offer the family far more support and, where necessary, to explore the impact of disability upon them - with the child, the parents, and the family as a whole. She regretted having to simply refer them elsewhere for something that might appease them, like a respite service.

The comments of these two respondents demonstrate a commitment to a wider professional brief, but one that they feel is restricted by the expectation that they prioritise other work. Their remarks contrast with the former two respondents in displaying a confidence that - given the time - they could fulfil an important role for families, a role that might not otherwise be filled by anyone.

Crisis Intervention

Moving along the child care teams' practice continuum, the examples given by Miss G and Miss B above demonstrate that the respondents draw distinctions between those families whose referral for a service can be dealt with in a straight forward manner, with minimal follow through, and those for whom a more sustained service is required. The criterion for some level of continuing service in the short to medium term appeared to be that of a crisis, which if not managed carefully might develop further and have serious consequences for the child and family.

In explaining her role with disabled children in such situations, Mrs P described her management of a very complex case. However, before Mrs P gave this example she expressed reservations about the sufficiency of her knowledge and skills concerning disabled children. She remarked 'I've got so little experience - I'm really struggling.' This was despite fifteen years of practice experience since qualifying.

The situation Mrs P described concerned a young adolescent who was self-harming and whose parents were desperate for help. The hospital consultants were unsure whether this young person had learning disabilities or a mental health problem, and either way they considered the hospital an inappropriate setting for her care. The consultant referred the young person to the child care team because he thought a placement might be needed as her parents were struggling

to cope with her needs at home. Mrs P described her role in dealing with the crisis situation as follows:

Getting an assessment done, arranging a planning meeting, inviting everyone, liaising with the specialists, working in partnership with the parents, arranging a placement - all immediately!

Mrs P considered that her approach to this sort of complex referral accentuated the particular assessment skills that social workers possess. She described her approach as identifying the needs of the child and their parents in partnership with them. She provided them with information about the options available for managing the problem and endeavoured to empower them to make an informed choice.

Mrs P highlighted how, in this case, she took the lead in liaison with the psychiatrist, the psychologist and the specialist social workers in both learning disability and child psychiatry services. Thus, she used all her knowledge and skills to deal with an urgent situation in the short-term. If she required more knowledge, she consulted specialist colleagues so that together they could provide a fuller social work response.

Mrs P's approach demonstrates her use of social work values in practice, and to some extent shows how the social model of disability informed her work. She displayed a commitment to collaboration with other professionals and to consultation with the family, and she identifies this approach as distinctive to social work. Her example also shows that others were willing for her to take the lead, at least in certain aspects of the assessment and care plan.

The example is very interesting. The compliance of other professionals with the social worker may be interpreted in different ways and these can contribute to understanding the social work potential to overcome collaborative difficulties. Mrs P used her skills in collaboration to draw professionals together to sort out a crisis situation. She overcame collaborative difficulties,

and this provides evidence that it is possible to do so in a crisis. Perhaps, as in 'child protection' generally, the crisis and the risks involved to the young person's safety, effectively 'force' professionals to co-operate. Considering the old adage that there is nothing quite like a crisis to focus the mind, perhaps in these situations professionals find themselves having to look at what others can contribute towards a solution. If the social worker manages the case well, they may rise in the estimation of others; and this recognition could go some way towards breaking down the barriers to effective collaboration.

However, the need for an expensive resource, which the social work agency might finance, could also draw professionals towards co-operation. There is a suggestion in Mrs P's example, that her liaison with the other professionals may have been seen by them as fulfilling a sort of 'super clerical' role, rather than collaboration with a professional equal. This was highlighted in Mrs P's comment concerning other professionals' understanding of her role:

I think that they are clear about the social worker's role in organising a meeting, collecting and sharing information etc., in crisis situations, but not clear about social work assessment skills. There is an awareness that everyone, in a multidisciplinary way, has a role, but the roles are not defined.

From her account, Mrs P's assessment seems to have provided insights that enabled the team of professionals to reach conclusions that had great significance for the child and their family. For example, her conclusions assisted others to formulate a diagnosis and in the light of this to recommend an appropriate placement. However, Mrs P suggests that her contribution to this may not have been recognised, and this may reflect the relatively low status of social workers' opinions and knowledge in comparison with the other professionals involved in this case.

Mrs P's perception that other professionals are not clear about her role may be related to her own uncertainty about the role, and to her lack of confidence concerning those aspects of her

work that are distinct. Because of the significance of this matter, and because it was mentioned by several respondents, it is explored under a sub-heading below.

Mrs P's case example also contributes to understanding about how the social work potential to overcome collaborative difficulties and practice weaknesses is limited where the main focus of practitioners' work falls on dealing with crises and child protection. Such an approach seems to restrict social workers' opportunities to promote their role and develop collaborative relationships. Two reasons for this are apparent. First, they simply do not have the time, they are in a rush, and everything has to be done 'immediately'. Second, they neither have the time nor the capacity within their caseload to follow through many of the needs of the families that they identify. Thus, they have to deal with the task in hand and then move on quickly to the next.

Lacking confidence

Mrs P's account of her work above demonstrates her commitment to professionalism and an advanced level of skills, which she used in consulting with the young person concerned, working in partnership with her parents and in making all the arrangements necessary for a young person in crisis to be placed in accommodation away from home. These are complex tasks indeed, yet she paved the way for her example by expressing doubts about the sufficiency of her knowledge and skills.

Similarly, Mrs C said that she did not know what to do for disabled children; she would call the specialist. However, later in the chapter an example of some work she did with a young person with learning disabilities is discussed that demonstrates considerable skill.

Mrs G, also commented that she would not have a role with disabled children at all unless there were serious family problems, such as parents struggling to cope with the child's behaviour, and even then she thought that a psychologist might be better equipped to help than her - and she concluded:

I feel a lack of confidence. I did a lot of study regarding [a specific disability] for a child I knew, and at the end I still did not think that I could have much input - education were the lead.'

Three other child care social workers judged themselves lacking in the knowledge and skills required for child disability work. Moreover, they concluded that when this was combined with their lack of time and the limited practical resources available to support them in disability work, then they had very little to offer. Those that felt this way were inclined to consider that all disabled children should receive services from a specialist team.

These social workers' perceptions of their own limitations, their lack of confidence in the value of their contribution, and the way in which they underestimate their knowledge, skills and values can restrict the potential that is otherwise evident in much of their work. Such uncertainty is likely to be reflected in the confidence with which these social workers collaborate with other professionals and negotiate their roles. The discussion of collaborative working in Chapter 2 noted the importance of professionals having confidence in their contributions if they are to achieve recognition for their work, which is important for their status and ultimately for achieving effective collaboration.

Social workers as handmaidens

Mrs P's account also demonstrates how social workers may be called upon to resolve certain matters not because they are seen to be appropriately skilled for the task, but because

other professionals see the task to be the social services' responsibility. In this case there was a need to identify and secure a placement because the doctors did not consider it appropriate for the young person to remain in the hospital. Several other social workers, including the specialists, made similar remarks about other professionals' agendas when referring children to them. Mrs W, for example, thought other professionals sometimes 'choose to view social workers to suit their own needs.' She found, for instance, that hospital staff sometimes treated social workers 'As a resource procurer - and that is it! As a hand-maiden to others, such as consultants.' Mrs W explained that there had been occasions when she had 'to put it to doctors that it was time to take the social work role seriously in an age of interprofessional working.'

Mrs H, Mrs G and Mrs C all stated particular concerns about teachers who only contacted them when they wanted a particular resource or service. Mrs H said that this made her feel misunderstood and unappreciated as far as her role with disabled children and families was concerned, and she experienced her role constrained as a consequence.

These respondents' views about collaborative difficulties provide some insight into how social work potential can be restricted if understanding of the social work role is limited and if it is not promoted. This survey finds, as discussed above, that there is a lack of confidence among social workers. They are not promoting their role because they are not confident about their competence in it. Even those who perceive their role to be about arranging services do not promote it because they lack confidence in whether they can secure the particular services that families might need. Others have made efforts at promotion. Mrs J for example, thought that the traditional attitudes of hospital staff towards social work was affecting her role. She tackled this by publicising her work and giving presentations to staff. Perhaps at a local level her efforts can go some way towards overcoming difficulties in collaboration. However, this thesis finds that

there is unlikely to be much change until more substantial efforts are made to improve the status of social work. The views of other professionals, which are explored in the next chapter, reveal that many of them perceive that the social work role - or more precisely, social work practice - is all about 'gate-keeping' services.

The restrictions of time

Several of the child care workers said that they lacked sufficient time to talk with families.

The social worker should be able to spend time with the child, instead of referring out to family aides etc.; time to get to know the child and get to know their needs, we don't get enough time to do this... we are unable to build up a relationship with children. (Miss G.)

Miss G considered it the social workers' role to provide children and families with long-term support. Moreover, she thought this had particular importance because other professionals did not have the time to do this. Teachers could not give children enough individual attention because their classes are too large, and other professionals, like speech therapists and physiotherapists, have to focus on very specific issues. However, Miss G found it impossible to fulfil the role as envisaged. She explained that this was because 'there are too many demands on social workers' time,' and because 'it takes longer to build up trust with children with special needs.' She was concerned that managers did not always take this latter issue into consideration when allocating work.

Similarly, Mrs H was confident that she had the necessary knowledge and skills to competently assess the needs of disabled children. However, she found that 'the therapeutic possibilities' within her interventions were limited by the demands of more urgent work. She remarked:

I would love to do counselling but my caseload makes me unreliable. I would like to see social workers able to do this, who do not have child protection on their caseload.(Mrs H.)

Mrs H stressed that effective counselling requires social workers to be committed to 'time and place.' She considered the availability of long-term support and counselling to be particularly important for disabled children and families. Considering the restrictions on the child care social workers' and the specialist workers' time she thought that a separate social work team dedicated to 'children with special needs' would be the best way to meet families needs for these services.

In view of respondents' claims about being pushed for time, the researcher made enquiries to service managers about social work caseloads to discover how far their claims were justified. The enquires revealed that managers judged the caseloads of most of their qualified staff to be at the maximum capacity and, in some instances, excessive. The increasing demands for child care social workers to be involved in the assessment and management of child abuse casework had, on the whole, caused their work to be oriented in this direction. Furthermore, their ability to be available for other social work was constrained by the need to be available to deal with urgent situations and crises that frequently occurred in child protection casework.

Child Protection: evidence of potential

The main reason, therefore, why child care workers find disabled children receive low priority on their caseloads is because of their responsibilities for child protection. Several respondents pointed out that disabled children were not on their caseload unless their names were on the child protection register.

Several respondents were much more confident that they had something significant to offer in child protection because of their skills. They were not saying that they had developed specific skills in the protection of disabled children - they dealt with disabled children in the same way as any other children on the child protection register.

Exploring this with respondents raised some interesting issues. For example, some child care workers fulfilled a keyworker role for disabled children on the child protection register. This entailed co-ordinating and monitoring the 'child protection plan'. In doing so, they were assuming a role that they did not consider themselves otherwise equipped to undertake, because they judged their knowledge and skills in child disability work to be inadequate.

Mrs A provided some insight into how this works. She acted as a keyworker for two disabled children and, in this role, she became a 'central point for others with concerns.' She assumed a co-ordinating role for all services arranged for these children and their families. Mrs A considered that this co-ordinating role should normally be undertaken by a social worker, even without child protection registration. However, she judged that a specialist social worker would do the work better than her because she had 'nothing specific to offer' as far as disability related issues were concerned. Moreover, she considered 'If I wanted to work with children with disabilities I would have a lot more learning to do - it is a very specialised role.'

Mrs A contrasts her role in child protection with that of other professionals, working with disabled children. Mrs A described herself as being 'at the sharp end' in child protection work, but she did not perceive the social work role for disabled children in a similar way. She explained that if professional intervention is viewed at three levels - primary, secondary and tertiary - then in disability, doctors, health visitors and the multidisciplinary specialist team are at the primary level. The child care workers are not at the sharp end, unless there are child

protection issues. Their role is secondary, or even tertiary, in that they may have some useful knowledge and skills to contribute and they may be able to access some helpful resources. Mrs A considered 'We can't all know everything - it is the way it should be.'

Evidence of avoidance

Mrs P's remarks suggest that social work potential may be restricted where the relevance of the role is not realised. Her perspective can be compared with Mrs C's, discussed above, and several other child care social workers, who considered that because particular knowledge and skills are required for child disability work, it would best be done by others with these skills, such as specialists. This may reflect their lack of confidence as discussed above, and their concerns about the adequacy of their training. However, it may also suggest an avoidance of child disability work, for the sort of reasons identified by Browne (1982) and Middleton (1996), which were discussed in Chapter 3.

One interpretation of this perspective is that the social workers might rationalise and justify some avoidance of child disability work because they have no time to do otherwise. Similarly, there may be no expectation from their managers that they do otherwise. However, a number of other reasons why social workers might seek to avoid disability work were either explicit or implied by the comments of those interviewed. First, some social workers genuinely consider that their knowledge and skills are inadequate, and they lack confidence in their abilities to supplement their existing knowledge and skills. Second, it may be that this is not their preferred work; it does not hold particular interest for them. One respondent was quite clear about this. Third, it may be that their views disguise discrimination, in that they consider work with disabled children and families less important than other areas of their work. This links with

the fourth possibility, which is that they lack of awareness of the special needs of disabled children who are being abused, who are at risk of abuse, or who have been abused. Finally, their views may demonstrate a limited perception of the social work role with disabled children; one that is based on a medical model of disability.

The respondents' comments demonstrate how each and every one of these matters can limit the social work role, even where the practitioner has considerable knowledge and skills that are relevant to disabled children and families. In Mrs P's case, for example, it is evident that she takes very seriously her child protection responsibilities for two disabled children. However, it seems that she may be avoiding consideration of wider issues, which she perceives to be specific to the children's 'disability', because she does not consider herself sufficiently specialist in this field of work and, therefore, not the right person to deal with these matters. The responses of other social workers suggested similar views. However, as Browne (1982) and Middleton (1996) had found in other localities, this seemed to be because they thought it essential to have a specialist's understanding of how the child's physical and/or intellectual impairment affects them and their family and, in the light of this, knowledge of the most appropriate interventions. Moreover, they thought that this knowledge was difficult to acquire. This may be avoidance and it seems to be based on a medical model perspective. Thus, as Middleton (1996) found the social workers may be avoiding responsibilities for disabled children because they consider it appropriate to refer to separate specialist services. The interviews with the specialist social workers provided some insight about these matters. It was mentioned above that neither of the specialists had experience of working specifically with disabled children prior to taking up their specialist posts. This is significant to the interpretation of avoidance because they both

consider it straightforward to transfer generic skills from other areas of social work with children and families.

Both the specialist workers thought that child care workers used their argument of inadequate knowledge and skills to justify requests to wholly transfer case responsibility, wherever possible, to the specialist team. They perceived that 'the child care workers saw them as having responsibility for disability work. Where it was not possible to transfer cases, because the child did not meet the team's criteria (of severe physical or learning disability), it was likely that the family's case would be closed after the 'presenting problem' or 'crisis' had been dealt with. This was because child care social workers could not commit themselves to long-term work.

The contribution to understanding how the social work potential may be restricted is provided by these respondents through the evidence that the main reason why child care social workers 'avoid' child disability work is because they are seeking to reduce pressure on their caseloads.

Unless the child is at risk, or if there are other statutory responsibilities, child care social workers cannot justify finding the capacity in their workload to provide a continuing service. In fact, the interviews with specialists from other professions, which are discussed in the next chapter, reveal their anxieties that even where there are child protection concerns there is resistance from child care social workers to make room for disabled children on their caseload. Hence, here is further evidence that social work potential is weakened by heavy caseloads and agency priorities. In terms of Browne and Middleton's suggestions that child care workers could take advice from specialist workers, the situation for these respondents was that they could not begin to entertain the idea of continuing with the casework unless essential.

Thus the views of these social workers suggest that they are not well supported by their agency in disability work. They all highlight the lack of time and appropriate resources available. Overall their responses suggest a sense of powerlessness to provide anything much that disabled children and families would value from them.

Evidence of potential

However, some child care workers who judged themselves ill-equipped for disability work nevertheless gave accounts of child protection interventions that displayed their ability to transfer knowledge, skills and values from generic child care work. Their accounts provide evidence of a 'potential' to address practice weaknesses and collaborative difficulties.

The account from Mrs P, for example, which was detailed above, in which she coordinated an assessment and placement plan for a child who was harming herself. Her intervention demonstrated proficiency in transferring skills and competence in collaborating with a wide range of other professionals.

A further example was provided by Mrs C, who thought she had very little to offer disabled children, and described her role as limited to 'monitoring and policing in child protection cases.' However, she mentioned some direct work that she had undertaken with a learning disabled teenager who was named on the child protection register. Her work with this young person on safe sex and assertiveness was agreed as part of the child protection plan. Mrs C considered herself skilled to undertake this work because she had done similar work before with young people - that is, she transferred her knowledge and skills to undertake this work with a disabled teenager because of child protection issues.

These examples show evidence of individual social workers' competence and professionalism and their ability to transfer existing skills and develop new ones for work with disabled children. However, the discussions in this section provide evidence that social workers have few opportunities to do this. They generally appear to be wary of taking responsibility in child disability work unless it is part of child protection work, where resources and specialists are available to support their intervention.

Distinctive Contribution

Social workers were asked for their views about what particular aspects of their work constituted a distinctive contribution in the collaborative care of disabled children. This enquiry was intended to get to the very essence of what they considered most important about their role. The discussions in Chapter 2 highlighted how collaborative difficulties can arise because other professionals tend to think that social workers fail to make any kind of distinctive and expert contribution in disability work. This causes difficulties because it affects the knowledge, skills and level of status that others credit to social workers (Dingwall 1980; Bruce 1980). The discussions in Chapter 2 also revealed the importance of social workers overcoming barriers to their contribution by defining and negotiating their 'task domain' (Dingwall 1980), and by asserting the relevance of their contribution to the child's welfare (Webb and Hobdell 1980).

Thus this questioning was intended to elicit that which social workers would be looking to negotiate and assert as their distinctive contributions. The discussions in Chapter 3 also highlighted the particular relevance of social workers being clear about and capable of articulating their contributions in child disability work because of the dominance of the medical model (Middleton 1996.; Morris 1997).

The thesis argued here concerning social work potential hinges to a great extent on social workers' understanding of why their role is distinctive and important. This is because the effectiveness of collaboration depends on professionals recognising and valuing each other's particular knowledge and skills.

Social workers' responses highlighted the importance that they ascribed to their contribution in five main areas: securing services; consultation and direct work with children; holistic assessment; social work values; the synthesis of knowledge, skills and experience. Each of these is discussed and consideration is given to the insights that respondents' views provide concerning their potential to overcome collaborative difficulties and practice weaknesses.

Securing services

Several respondents considered that their distinctive contribution lay in combining knowledge of services with experience of liaison with other agencies in order to secure services for families. This was the view of Mrs A, who commented that 'Child care social workers gain a unique scope and breadth of knowledge, while other professionals have more depth, not breadth.'

Similarly, Miss L considered that her distinctive contribution lay in her ability to help families identify and access services, and in advocating for them to secure these services. She thought that if other professionals did this they would be taking on tasks that are over and above what others expect of them. Miss L considered that her access to resources, which the Social Service Department's 'has a legal responsibility to provide,' constituted a distinctive contribution. Thus she considered her contribution in this to be unique by virtue of employment not professionalism. Although she considered her authority in this arose from her professional assessment, which was accepted because she is qualified.

These perspectives indicate the complexity that social workers face in securing resources, and the skills that they perceive to be required for the process. Discussions in Chapter 3 identified that the arranging services for disabled children is an important social work role. It is complex and it requires an understanding of how to go about maximising opportunities for disabled children to receive services that are fully integrated. The task requires an understanding of the services available from different agencies and collaborative skills to secure them. Thus accessing services may indeed constitute a distinctive contribution. However, among those who considered this to be so, the role was more straightforward than this. They did not mention promoting access to services, creating new services or facilitating integration for disabled children.

The perspective of these social workers is unlikely to help overcome collaborative difficulties. If the social worker portrays their primary role simply as a resource-procurer responding to the requests of other professionals, others may perceive them as semi-skilled - in the hand-maiden role that was discussed above - rather than as competent professionals. Furthermore, if the social worker does not demonstrate an understanding of the particular needs of disabled children and families they may cause uncertainty among other professionals about whether they have the skills to arrange appropriate services.

Communication and direct work with children

Direct work, communication and consultation with children stood out as an area of great importance to child care workers. This was work to which they considered they brought particular skills. However, such work was mainly limited to children in local authority accommodation and, as with other areas of their work with disabled children, respondents

complained that they rarely had the time to do it. This contribution of social workers was not without its problems. Several respondents considered that other professionals did not understand or appreciate the significance of this work - and this created collaborative difficulties.

Mrs H considered that her communication and direct work with children constituted a distinctive contribution of the utmost importance. However, in her experience other professionals failed to recognise this.

I have a holistic role... everything that is happening, particularly where we have responsibility for children in care. I have a frustration: as the most stable person in children's lives [those in long-term placement] I often feel excluded by schools and by foster carers - who have a view that 'normality' should lead to excluding the social worker! Yet, I am the only one who may have followed the child through several schools and placements.' (Mrs H.)

Mrs H considered that other professionals often did not appreciate the reasons why social workers had to form relationships with children and how they needed to consult with them on matters of importance to them and their future. However, the problems for Mrs H arose less from others not appreciating her skills and more from their disregard for her findings - that is, not liking what they heard. Thus, the challenge for Mrs H was to ensure that the child's wishes and feelings were given due consideration. The distinctive contribution therefore lay in highlighting the relevance of children's opinions, and advocating for them.

This difficulty in collaboration might arise for two reasons. On the one hand it may be that social workers are not recognised as having, and do not command status for, particular skills in developing relationships and communicating with disabled children, (this being Mrs H's interpretation). On the other hand, it may be that communicating with disabled children does not command status as professional work. Either way, Mrs H's experience was that the lack of recognition given to this work impeded constructive collaboration and her contribution to the child's welfare.

Another respondent, Miss G also considered that direct work she had undertaken with a disabled child in foster care was particular to her role as social worker. However, she did not consider herself sufficiently competent in this work to claim that it was a distinctive contribution.

This is an interesting perception. It suggests that the distinctiveness of the contribution relates directly to the competence with which it is performed. Thus it is the expertise used in the work that is distinctive.

Mrs G would not claim that her work was distinctive because she does not consider herself to have sufficient expertise in the task. Although she perceives the task to be 'particular' to social work, because it is a social work responsibility, she does not consider the task itself to be 'distinctive' to social work. Thus she does not expect 'recognition' - status - for the task of communicating with a disabled child in foster care.

However, there may be an implication in this for collaborative working and overcoming practice weaknesses. If this social work task is not considered to be distinctive and to warrant recognition as 'professional' then it risks being pushed to the margins when other work comes along that everyone more immediately and evidently recognises as important, such as child protection work. It may appear then to others that the social worker is inconsistent and uncommitted to the task of consultation with disabled children. Moreover, social workers' experiences of their inability to follow through consultation with children might cause them to avoid taking on such a task in the future.

Holistic Assessment

Many of the social workers considered their work distinctive because it was 'holistic'. However, this term seemed to mean various things to different respondents. Some used it to

describe their consideration of the child's and family's needs for social and recreational opportunities. Others used it to describe their attention to the different environments and agencies concerned with the child's health, education and social well-being. Still others used the term to describe their regard to the emotional and psychological needs of whole family, as well as the disabled child's educational, medical and social needs.

Mrs H thought that social workers made a distinctive contribution through their consideration of 'the whole picture, holistically, rather than any particular aspect.' She commented that the social worker's holistic approach towards their work with children in care was crucial and unique. She thought that social workers were well equipped to do this by virtue of their broad-based training.

Similarly, Mrs A, child care social worker, considered her 'wider scope of concern' to be a particularly valuable contribution. Nevertheless, she thought that this was not unique to social work because other professionals within the specialist team for children with learning disabilities could competently fulfil a keyworker role; and it was likely that they would make a better job of it than her.

However, in describing holistic assessment the child care social workers did not say that their approach was informed by a social model of disability, or even by a sympathetic understanding of the stresses and strains some families undergo in caring for a disabled child. It was more about saying: as social workers we look beyond health and hospitals, and education and schools, to consider the home environment and social opportunities.

This could be interpreted as meaning that social workers perceive home and community to be their professional territory. The hospitals belong to doctors and nurses, and the schools belong to teachers. The social worker puts the various parts together to achieve a whole or

‘holistic’ picture. However, this is not about giving attention to the impact of the environment in each of these settings on the child and family.

In the discussions of the social model of disability in Chapter 3, and of social work training in Chapter 5, the importance of social workers adopting a consistent and explicit approach to assessment was emphasised. Without this, and without explicit use of a particular theoretical and value framework, such as the social model of disability, it is unlikely that others will perceive social workers to be making a distinctive and expert contribution.

Other professionals experiencing a diverse range of approaches to assessment will find it hard to know what a competent professional ‘holistic’ social work assessment looks like, or what to expect from individual social workers.

Values

A further aspect of their work that most of the social workers considered to constitute a distinctive or unique contribution was that of their professional values. However, the child care social workers referred to values, which although significant, were not specific to work with disabled children. For example, they did not refer to the social model of disability as such in their comments.

Most of the child care workers did not talk about disability as that which children and families encounter because of their exclusion from normal life experiences, or because of barriers to their achievement. Neither did they refer to the vulnerability of disabled children to abuse, depression, and family breakdown. They referred instead to generic social work values. However, many of their remarks were in harmony with the social model of disability and the principles of the Children Act.

For example, Miss B considered that the ‘commitment’ of social workers to particular values gave their work distinctive features. These values included a commitment to anti-oppressive practice and to combating discrimination on grounds of disability, and a commitment to providing disabled children with services that enable them to lead as normal a life as possible. Miss B thought that while other professionals shared these values, it was unlikely that they were emphasised to the same extent during their training as they were for social workers.

Mrs P also considered that certain principles, which informed her interventions, were particularly important features of social work. These included working in partnership with disabled children and families when assessing their needs, and empowering them to make informed choices.

Neither Miss B nor Mrs P mentioned, however, that the dominance of the medical model in child disability work might mean that the application of these principles would be challenging for professionals accustomed to using a different perspective. This suggests that while there was recognition of the distinctiveness of the values there was less realisation of the importance of promoting them in multi-professional arenas where decisions are made concerning care plans for disabled children.

The synthesis of knowledge, skills and experience

Just one respondent mentioned this final example of a distinctive contribution. However, it is worth discussing in detail because it provides an example of a social worker who is confident in the importance and distinctiveness of their role. Moreover, it captures some of the essence of professionalism in social work.

Mrs W considered that social workers definitely have unique contributions to make. She stressed that these were not about access to services, or knowledge of the benefits system, or even about counselling, or communicating with children - although these are all important. The unique features she identified in the contribution were evident in three linked areas. First, other professionals turn to the social worker when there are issues to deal with that require knowledge of child care law or child abuse. Second, the social worker's knowledge base is unique compared with anyone else's in multidisciplinary work: social workers have a combination of knowledge about child care, the law, child abuse, the management of risk and intervention in complex family situations. Their use of this knowledge in practice enables them to develop skills that are particular to their profession. Mrs W thought that other professionals often failed to appreciate that social workers deal with highly complex matters of a kind that they might never have to address. These matters include serious personal and family problems, such as violence, serious debt, acrimonious family relationships, depression, self-harm and child abuse. Others do not usually deal with such issues because their role does not require them to, and because they can refer them to the social worker. Third, Mrs W considered that it is a unique contribution of social work that their practitioners must tackle these difficult matters concerning human behaviour and emotions, including child abuse. They cannot simply refer this work elsewhere.

Mrs W considered that there is a perspective and approach that other professionals do not have, and could not have, because each of the aforementioned elements are not essential to them. Others in health and education, even specialists, would never do things that social workers do in their professional life. Furthermore, the social worker needs to develop a range of knowledge, skills and reliable methods of intervention to tackle these issues competently and professionally.

Thus, what Mrs W considers to be a unique contribution reflects the arguments of Butrym (1976), which were explored in the discussion of professionalism in Chapter 4. What makes the contribution distinctive is that it requires social workers to use understanding that can only be acquired through their practice experience; it requires the social worker to carry responsibility for complex matters that are very personal to disabled children and families; and it is also about being able to impart some of this knowledge to others. As Chapter 4 demonstrated, Butrym (1976) and Payne (1996) have argued that it is these features that characterise social work activity as 'professional'.

Mrs W's contribution to understanding social work potential lies in showing how important to the social workers' confidence is an understanding of their own role and distinctive contribution, and their ability to articulate it for other professionals. Mrs W had learnt the importance of this from working within a multidisciplinary team. This had crystallised for her the distinctive elements of her role.

Mrs W did not argue that social workers take a holistic approach where others do not, neither did she claim that social workers make better key workers than others; or that child protection is solely social work territory. What she put forward was a view that qualifying training provides the foundations upon which social workers can build something unique (the combination of theoretical and practical knowledge, and the development of self awareness); and it is through the social workers' professional development that they learn how to apply their knowledge in assisting people in highly complex situations.

Mrs W emphasised, however, that not all qualified social workers develop skills of this nature:

Individuals qualifying in social work cannot simply adopt skills such as integrity and sensitivity as required to undertake counselling, etc., they must possess these attributes as a base - otherwise they could not sustain them.

Perhaps this allows us to see why some of the health and education professionals preceded their remarks about social workers by saying 'it varies', and 'it depends' on the social worker. Mrs W highlights how different social workers develop various levels of insight and competence during their working careers. While this is the case in all occupations, there is a particular significance for social work in collaborative working. Unless there is a standard by which other professionals can recognise a 'professional' level of competence from all social workers - that which can serve as their starting point for expectations - then they are unlikely to assume professional competence from social work. This is because, as suggested in the discussion above concerning holistic assessment, they are unable to accurately anticipate what they will receive from social work involvement. Thus, it is more likely that they will wait and judge what they make of the individual. This places a substantial challenge on the shoulders of every social worker in collaborative working because they are almost always starting from scratch to establish their credibility.

Changes in Practice

The following discussion considers social workers' thoughts on whether their practice with disabled children and families had changed because of new legislation or policy initiatives. Considering the increased emphasis on interprofessional collaboration in legislation, the enquiry sought social workers' views about whether this had led to any noticeable changes in their practice or their relationships with other professionals.

Both the specialist workers considered practice, had been influenced by principles established by the Children Act 1989. This was most notable in the establishment of the multidisciplinary team for learning disabled children, which was underpinned by principles of joint agency working and consultation with parents in service planning. They also considered that with this initiative there had been a shift in the orientation of multidisciplinary assessment work from being parent-focused to a child-oriented approach.

While the specialist workers both considered their positions within multidisciplinary teams to be highly significant, they also thought that the development of services for disabled children was falling short of what was needed. They considered that the team's development had been restricted by the lack of sufficient investment. This meant that children with physical disabilities did not get anything like the same level of service as those with learning disabilities. Furthermore, the team's services remained available only to those with the most severe impairments. They judged that the reduction in ring-fenced funding of learning disability services by central government through the 'All Wales Strategy' was having an adverse effect on service provision. Mrs W considered that 'the cracks in services are already appearing.'

Nearly all the social workers interviewed had been in the employment of the local authority during several major reorganisations of children's services, all since the Children Act 1989 (as detailed in Chapter 8). Despite these changes respondents considered that little had been achieved by way of improvements in services for children and families. While some respondents thought that some additional services had been developed, others thought not.

Some respondents commented that their contact with disabled children and families was so minimal that they were not able to give an informed opinion as to whether these changes had affected services for these clients. Other respondents considered that their contact with disabled

children had reduced because of the changes. Their comments reveal the blighting impact that child protection has had on social work with disabled children and families.

The blighting impact of child protection

As discussed in earlier chapters, there has been, and there continues to be, substantial concern about the impact of child protection work on services for disabled children and families. From BASW (1992c), who were concerned that priority given to other work would continue to overshadow the needs of disabled children and families. From Middleton (1996) who argued that a collusion of ignorance and self-interest led to substantial investment in child protection while disability work lay neglected. From Rickford (2000) who identified families who had difficulty meeting the criteria for services. And from Hooper (2001) who could not get an assessment for her own disabled son because he was not 'a child protection case.'

All of the child care workers interviewed said that changes in legislation and subsequent reorganisations had shifted the emphasis of their work to child protection, legal intervention, and children accommodated as part of child protection plans.

Mrs P considered that the focus of her work had shifted significantly towards child protection. 'Children with special needs are still referred, but usually only if there is a child protection issue. Otherwise, they are not a priority and may be left behind.'

Miss L observed an 'imbalance' between child protection and generic child care social work in favour of the former.

Mrs C considered that the effect of this concentration on child protection was that there had been no developments for disabled children. She judged that 'things seem more difficult to get for children in need.' She argued that one reorganisation of children's services, which

entailed the creation of a new senior management tier, had 'simply led to another manager being in a position to refuse resources!' She explained that this arose because managers had established what they referred to as 'clearer criteria' for services - she perceived this to mean that clients for whom social workers used to be able to secure services were no longer eligible for them. For example, respite services that could be arranged for children with special needs were, since reorganisation, now only available for children with more severe disabilities. Mrs C perceived the management explanation that this was because of the need to 'target those in greatest need', to be a thin disguise for restricting access to services for children with lower level needs and for justifying unacceptable financial constraints.

In contrast, Miss G considered that a wider range of support services had become available through the flexibility offered by the Section 17 budget for children in need (under the Children Act 1989). This provided finance to enable children with special needs to access mainstream services such as playgroup and child minding sponsorships. Overall, however, Miss G considered that practice with disabled children and families would be restricted from improving further, to any significant degree, unless the authority was able to employ more qualified staff to meet the needs.

Similarly, Mrs H thought that 'special needs is on the agenda more' and that changes in some local authority services had been beneficial. For example, the closure of some segregated special schools meant that teachers were becoming more open to recognising their responsibilities to disabled children. However, she perceived that such changes were driven as much by financial considerations as by good practice, and this tended to cause matters to be rushed, and insufficient consideration to be given to putting alternatives in place.

The rhetoric and aims are admirable, but we still fail to meet the needs of special needs children within mainstream facilities - safety nets and additional resources, which such children need, are not in place. (Mrs H.)

In similar vein, Mrs D considered that many disabled children were 'unknown' to the Social Services Department. She said that these children were 'lost to services.' She explained that, in her experience, many children and families who should be rightfully be assessed as 'in need' under Section 17 of the Children Act were not assessed as such. These families did not get a service from the Department, unless there were child protection issues, because their disabilities were not of the nature or severity to require referral to the specialist team. Mrs D considered that:

It is taken for granted that there is a specialist team, and that this is the reason why the Child Care Team does not deal with referrals concerning children with special needs.

As a recent employee of the authority, Mrs D's opinions were not based on changes that she had witnessed in the authority, but on her experience of current practice in mainstream children's services, which she felt was completely dominated by child protection.

None of the child care workers considered that changes in legislation, policy and the organisation of services had improved collaboration with other professionals concerning disabled children. However, they all thought that it had improved in child protection work.

These findings suggests that where there had been improvements in practice with disabled children and in collaborative working they could be directly related to new structures, which had been introduced to accommodate new ways of working arising from the influence of the Children Act 1989 (and associated policy guidance). Hence, for disabled children improvements in collaboration were commented upon because of the creation of a multidisciplinary team. However, the comments of respondents demonstrate that improvements in interprofessional

collaboration have not extended to professionals outside the team. Improvements in collaboration in child protection seem to have come about because of the development of social work teams designated to respond to child abuse investigation, and because of the concentrated focus on child protection work within the child care teams.

The Ideal Social Worker: unencumbered and overcoming limitations

Respondents were asked to describe their 'ideal' of a social worker for disabled children and families. This enquiry was prompted by the discussions in earlier chapters concerning the roles and responsibilities of social workers, which revealed that weaknesses in practice could be accounted for by a variety of reasons associated with both the social worker (their knowledge, skills, values and commitment to professionalism) and their agency (providing adequate resources and appropriate structures for service delivery). The purpose of this enquiry was to gather social workers' opinions on the key components that characterise the best practice in the field, and to hear their views on what practice would be like if there were no restrictions. It was anticipated that this line of questioning would bring to the fore respondents' opinions about what was restricting them from practising with the competence that they would prefer. This section compares and contrasts their views of the ideal with their own practice, and draws conclusions about what might be preventing them from fulfilling their potential.

All the social workers considered that in an ideal practice situation the social workers' caseload would be sufficiently manageable to allow them time to spend with children and families, time to use their knowledge and skills in assessing families' needs comprehensively, and time to look at alternative ways of meeting these needs. This ideal contrasted starkly with their own practice situation, where they had little time for any of these things. Most of the

respondents envisaged that an ideal social worker would also be unencumbered by the immediate demands of child protection work, which, as the discussions above have demonstrated, they experienced as restricting them from committing time to disabled children and families.

Even the specialist workers considered that the greatest impediment to achieving best practice in their work was the lack of time. While they were pleased that working in a position dedicated to disabled children freed them from many of the immediate demands faced by the child care workers, they nevertheless had to deal with many referrals of families in urgent need and crises.

Mrs J considered that ideally the social worker would be able to commit to providing children, parents and families with structured counselling, where necessary making time for both parents to be met together. Ideally the social worker would be able to go out of their way if necessary to meet with fathers of disabled children, who were usually absent during social work visits. Mrs J commented that fathers sometimes opted out of family life altogether because they could not cope with the demands entailed in caring for a disabled child; and a social worker with time available could help by providing counselling.

Both the specialist workers considered that ideally a lot more could be done to address the transitional needs of young people leaving school.

Several respondents stressed the importance of communicating with disabled children, which they considered an essential component of their work, which had nevertheless become an ideal. They thought this situation had arisen mainly because they could not reserve or prioritise time, yet they also judged themselves insufficiently trained for the task. For example, Mrs A reflected on her role in child protection with disabled children and remarked that forming a

relationship with the child was essential to the proper fulfilment of that role. However, she had no training in this and lacked confidence in her ability to communicate with disabled children.

Some of the respondents considered that the ideal social worker would have access to a range of resources to support their work with disabled children and families. Contrasting this ideal with her work, Miss B said that resources were most inadequate: 'I don't think social services have really addressed needs and resources for disabled children.'

Similarly, Mrs H thought that services and resources were inadequate and often unsuitable for disabled children. She considered that ideally social work would be more creative with resources: 'What we have to offer has to be more innovative.' She considered that ideally budget-holding managers would take time to hear the views of practitioners when developing services in order to have their perspective on the sort of services that could be most helpful. It was interesting that, considering the focus of this research, she judged that service planning for disabled children failed to address needs effectively because the arenas in which interagency planning took place did not provide practitioners with an opportunity to influence plans.

Section 2: Social Workers' Experiences of Collaborative Working

This section discusses respondents' opinions about how other professionals collaborate with them. Social workers were asked whether they thought that other professionals understood their work. The researcher intended that this questioning would discover whether the conditions for the development of the positive individual relationships that other commentators have found necessary for effective collaboration - such as knowledge and appreciation of others' roles and responsibilities - were fulfilled in the locality where the research was conducted. Respondents were also asked to describe difficulties that they experienced in collaboration and to suggest how

these might be resolved. This line of questioning was pursued because the researcher considered that solutions informed by practitioners' experiences that go to the heart of the problems as they perceive them, and which can be applied in ways that they consider most helpful, may be most likely to succeed.

Others' understanding of social work

The two most recently qualified social workers commented that they did not know whether other professionals understood their role and skills. This was somewhat surprising considering the increasing emphasis on collaborative working with the introduction of Community Care and Child Care legislation. Their responses suggest that while an emphasis may have been placed on the importance of collaboration, the knowledge and skills required for achieving it effectively were not explored.

Miss L thought that other professionals' understanding of the social work role varied. She thought that understanding was improved between professionals when they got to know each other well. She remarked: 'The people I get on best with are people I have got to know, and they have got to know me.'

Miss B judged that other professionals' knowledge of social work was inadequate. She thought their views of social work reflected 'lay' opinions combined with their experience of unqualified workers and child abuse investigations. However, she conceded that there may be some good reason for this: 'It is hardly surprising that teachers have very limited knowledge of social work, because of the limited number of disabled children on our caseloads.' This view lends weight to the importance of others' day-to-day experiences of social work, rather than on any training or information they might have about the profession. This position was evident

within the comments of most health and education respondents, which are explored in the next chapter.

Miss B considered that improving other professionals' understanding about social work is not simply a matter of education; it is about social workers making an impression through their work. This she thought required social workers to respond creatively to the needs of disabled children - and not just because of child abuse. She said that in child protection training and practice, priority is given to time for understanding each other's roles and for collaboration, but this is not the case for children with special needs.

Mrs J thought that health professionals, particularly doctors, were less welcoming and less interested (than teachers) in the social work role. She had tried to 'educate' them about the role.

Sometimes other professionals need informing, or reminding, of the extent of social workers' knowledge and skills - there can be a misconception that the social worker's role is limited, for example, to sorting out benefits. (Mrs J.)

Both Mrs J and Miss B, and other respondents, considered that other professionals sometimes chose to view the social work role to suit their own needs.

Perhaps some light can be shed on this perception by the finding that 80 per cent of health and education respondents in this survey said that their knowledge of the social work role was insufficient. Their knowledge in fact varied considerably; and this could account for why their requests for social work could vary from a referral to sort out someone's benefits, to asking for help in complicated and crisis situations.

Experiences of collaboration

When asked about their experience of collaboration respondents' instinctive responses were that it was good - that relationships were positive.

Mrs A, for example, said that in her experience 'people are as helpful as they can be.' She had close liaison and good relations, particularly with some health visitors. However, she thought that any closer collaborative working could only be achieved within multidisciplinary teams.

Despite such positive instincts, when asked to discuss their experiences in more detail, most respondents struggled to find examples of good collaborative working. They referred instead to difficulties - with health, housing, the DSS, foster carers and, most of all, with education.

Mrs C, for example, who began by saying that her experience of collaboration had been 'very positive', went on to comment:

I have been very fortunate, right through, even housing! Health visitors, police, everyone - the only sticky ones, now and again, are education, particularly educational psychology - I have never been able to agree with them. Doctors are not keen on coming to meetings, etc., but they do if you apply pressure. I have never had a referral from a doctor! (Mrs C.)

Similarly, Mrs H thought that collaboration had improved since the introduction of the Children Act 1989, and yet she said:

It can be difficult...Education and schools are most difficult, and while health visitors have got better, GPs don't want to be involved - they see themselves as important key people, but they do not liaise.

The contradiction between social workers' positive feelings about collaboration and their concerns about it was highlighted by Mrs P, who said:

It (interprofessional collaboration) works very amicably, which is a good foundation...mutual respect is a primary issue, whilst hostility would be a barrier...the gravity of situations should provoke professionals to work together collaboratively.

Mrs P highlights how, as discussed above, collaborative working may appear to work more effectively when everyone is focused on matters of urgency. However, Mrs P said that, despite the gravity or urgency of situations, she was sometimes shocked at the poor collaboration of other professionals. For example, a delayed response from a psychiatrist concerning an urgent matter, or teachers not doing anything about a child's evident difficulties in school.

The social workers' responses may be interpreted as indicating their desire for positive relationships with other professions, accompanied by their doubts about whether their efforts in this direction led to any lasting or general improvement. For example, several respondents reported that although teachers always welcomed them at schools, and seemed interested to know what their work entailed, they rarely followed-up the liaison. Miss G commented that the initiative to contact teachers to discuss their work rests with her: 'They do not do it the other way around, to find out about me.'

Likewise, Mrs P thought that there was room for improvement in collaboration with teachers. She discussed a case where a teacher criticised her work. Mrs P blamed herself for this 'misunderstanding' and said, 'Perhaps if I had explained to the school, they might have understood.' A markedly different opinion was expressed by Mrs H, who had frustration about teachers who were 'good at communicating prior to resources being in place, but after this they seem to exclude you.'

Mrs H described a case in which she and a specialist social worker could not agree with the teachers about the needs of a child. Despite their efforts to explain their assessment to the teachers, their recommendations were ignored and the case was closed without, to anyone's

mind, a satisfactory resolution. Mrs H considered that if she had been able to continue with the case in the long-term she would have argued her position more persistently.

This example from Mrs H contributes to understanding of how social work potential may be restricted for two reasons. First, the unwillingness to accept the conclusion of the social work assessment, despite input from the specialist, might suggest that the teachers were uncertain about the process of social work assessment, the competence with which social workers can undertake such a task, and the relevance of their knowledge and skills. Mrs H gave the impression that this was indeed the major barrier to effective collaboration, which would have required considerable effort on her part to resolve. However, her ability to do so was not aided by the second reason, which was that she closed the case. Collaboration would not have been assisted by her inability to see matters through to a more satisfactory conclusion. This might lead to others questioning social work commitment to disabled children.

Following the theme of misunderstandings between professionals, Miss G thought that teachers' reluctance to liaise with her might relate to their concerns for confidentiality. In her experience, teachers preferred to talk directly with parents about problems, rather than to contact the social worker. Considering this social worker's perception in the light of the survey of other professionals reveals how misunderstandings can arise, because some of the teachers interviewed thought that the lack of information shared by social workers might be due to social workers' concerns for confidentiality.

Two other social workers, Mrs H and Miss L, who held case responsibility for disabled children in foster care, judged that other professionals, particularly teachers, often 'excluded' them from information concerning these children. Mrs H remarked that she always has to take the initiative to liaise with them if she needs information.

The experiences of these social workers suggest that although they wanted to express positive views about collaborative working, they realised that it is not simply about being friendly and welcoming, although this is a good foundation - it is about understanding professional roles and skills etc., and having opportunities to examine certain key issues together.

Overall the comments of respondents suggest that they do not consider their work to be understood by others, and this well-known barrier to effective collaboration causes considerable difficulties for them. What the discussions in the next chapter reveal is that these difficulties arise mainly because of other professionals' uncertainty about what social workers do and the competence with which they do anything. Often others do not share information because they do not realise that they need to, or they are not sure that it will be an effective use of their time. However, in child protection things are somewhat clearer. They realise the importance of sharing information, regardless if they do not want to be held responsible if things go wrong.

On a positive note, one respondent felt that the Children Act - or more precisely the training that accompanied its introduction - had motivated professionals to communicate more effectively, and she reflected; 'I think it was very, very useful - all professionals coming at it at the same time, sharing knowledge and views.'

Achieving Effective Interprofessional Collaboration

In discussing how collaborative difficulties might be resolved, most respondents tended to blame themselves or their agency for any shortcomings. However, they considered that their shortcomings were generally brought about by the circumstances of their work, and so it was to the agency that they looked for solutions.

All the respondents considered that the most significant barrier to improving collaboration lay in their lack of time for liaison. Mrs D said 'being busy makes it very difficult to liaise.' Mrs P said that she has little time available to gather information or to give feedback - and so she said, 'I phone up later and apologise.'

Respondents considered that their managers needed to realise how heavy caseloads focused on child protection work compromised their ability to fulfil other important tasks. They judged that the only feasible answer to this dilemma was for the agency to employ more social workers. Some respondents suggested that these additional workers would be best placed in the child care teams so that everyone's caseload could be reduced and they could all be freed of some child protection work to enable them to spend more time with children and families and more time working with other professionals. Thus, respondents considered that if they had more opportunities for practice this would enable them to improve practice, and thereby to overcome collaborative difficulties.

This perspective was reinforced by Miss B, who said that the weight of her caseload prevented her from dealing as she would like with issues that arise for children with special needs. She considered that many situations for disabled children and families require extensive assessment, intervention and interprofessional collaboration, which she does not have the time to commit to because of the demands of child protection work.

Similarly, Mrs D described the frustration that the orientation of her caseload caused her:

I feel sometimes that I am just scratching the surface - you don't have time to give to sit and talk with people... I feel like I am just applying a sticking plaster... Always rushing! A quick half hour, and off!

As discussed earlier, other respondents said that the lack of services to offer disabled children caused collaborative difficulties. It adversely affected their relationship with other

professionals and impeded collaborative working generally. Thus the solution proposed was that the agency should increase investment in those services that disabled children and families find most helpful.

Section 3: Social Work Training

This section explores social workers' views of their qualifying and post-qualifying training and how it equipped them for work with other professionals and in the care of disabled children. Without exception the social workers judged that their training had failed to provide them with adequate knowledge in both these areas.

Five of the respondents had received no instruction in child disability work whatsoever during their qualifying training. Where matters concerning disability were covered, respondents said that the teaching had not addressed the needs of children and families or the role of the social worker. None of the social workers had studied collaborative working or the roles of other professionals during their qualifying training; and none of them had received training on the Community Care Act 1990.

Two respondents, Mrs C and Mrs D, were particularly critical of their qualifying and post qualifying training. Mrs C qualified with a CQSW in 1988. She said that the only opportunity she had to study disability issues during her course was through a 'disability awareness workshop'. In this, students were blindfolded and asked to talk about their experience of being deprived of sight. She had not found this helpful. Moreover, since qualification, she had received no employment-based training concerning childhood disability, despite having disabled children on her caseload.

Mrs C commented that in her current job, child protection concerns with respect to disabled children are on her caseload are discussed during professional supervision, but the disability issues are not. Mrs C considered herself disadvantaged as a social worker because of the local authority's failure to provide her with the training and resources needed to support her

work with disabled children and families. She also remarked that she did not have enough time to consult and learn from the specialist workers.

Mrs D studied a 'child care option' as a module of her DipSW course in 1996. She was unhappy that the course generally gave her 'inadequate tuition and guidance'. She said that this module focused only on legislation and child protection - it did not consider disabled children at all. Furthermore, although her training included an examination of the responsibilities of the DSS and housing agencies, it did not address collaboration or explore the roles of health and education professionals. Mrs D also criticised the lack of employment-based training provided by the local authority. She commented that whatever knowledge and skills she had gained were 'acquired' from practice experience. She did not think that this was an appropriate or effective way of learning.

Only three other social workers said that child disability work was mentioned during their qualifying training. Mrs H perhaps received the most comprehensive training. She said that her course examined 'a service-model for children with special needs.' She recollected that within this model the social work role was defined as 'empowering parents to use the available facilities.' Furthermore, during her placement studies she explored how this role could be fulfilled through group and community work. Her training also looked at socialisation issues for disabled children.

Miss B's training was rather less comprehensive. The course examined the major childhood disabilities, and an essay assignment was set on this.

Mrs W commented that a pre-qualifying NVQ course that she undertook had provided good teaching on disability issues, including a psychologist and a social worker presenting an

‘awareness’ workshop. On her qualifying course she recalled a presentation on disability by a medical consultant.

Overall, respondents expressed unhappiness about their qualifying training. Their comments suggested that their lack of training in child disability social work contributed to their lack of confidence in practice and collaboration. Unfortunately, it seems that there were few post qualification opportunities that they could take to address this.

Employment-based Training

None of the respondents had undertaken any employment-based training that was specific to social work with disabled children. Only one respondent, Mrs C, thought that there was an in-house course available. However, she had not been able to prioritise doing this training above other work demands. This was a theme raised by most respondents. Time out for training was perceived as something of a luxury. Being away from work for training created pressures on their caseloads, because adequate cover arrangements could not really be provided. Hence, they only attended training if it was very relevant to their day-to-day responsibilities or if they were required to go on it by management.

All the social workers had been required to attend training on the Children Act 1989, at what they referred to as an ‘introductory’ level. Several child care workers said that disabled children were sometimes mentioned during these training courses, but that they were essentially concerned with child protection. Mrs A described this as ‘by the way’ training, to indicate some small consideration being given to issues pertinent to disabled children.

This was also the case with training on collaborative working and the roles of other professionals. However, some matters were covered in child protection training, which most of

the respondents had attended. Mrs P said that she had never received any training concerning collaborative working in the care of children with special needs ‘not like you have in child protection - no opportunities to pick each others’ brains and understand each others’ perspectives.’

On a positive note, Mrs W judged that the authority had provided her with good training opportunities. She remarked that the in-house training had been excellent before the county split up into much smaller unitary authorities. There had been a large training section with trainers specifically employed to teach disability issues. However, the new county could not afford such training. Nevertheless, she considered that there were still some excellent resources available for reading and research available in the training section, the hospital library and the Family Support Team. Mrs W considered it to be her own responsibility to raise her training needs with the training manager. However, she commented that the demands of her workload prevented her from attending courses that might be helpful.

In summary, the social workers responses to enquiries about their training revealed that as far as the social work role with disabled children and families was concerned, there was little available at qualifying and post qualifying levels. Furthermore, the emphasis on collaborative working was almost exclusively directed towards child protection work. Considering the discussions in Chapter 7, regarding the importance of social work training, this finding provides evidence of its continuing inadequacy. This is despite CCETSW’s requirements for the CQSW and the DipSW (CCETSW 1975; 1991), and despite the urging of researchers such as Browne (1982) and organisations like Mencap, that greater priority be given to disability in qualification training.

Moreover, the expectation from CCETSW that employers enable social workers to develop their knowledge and skills as required for practice through post qualifying studies (including in-house training) had not led to training opportunities in child disability work for the social workers interviewed for this research. Their comments suggest that even if training in child disability social work was arranged they might not be able to avail themselves of it because of other work demands.

Conclusion

In exploring social workers' interpretations of collaborative difficulties and practice weaknesses, this chapter has identified the following key themes relevant to the thesis that they have the potential to overcome these problems and to fulfil a leading role in collaborative care for disabled children. First, that child care social workers perceive that their practice with disabled children and families is greatly restricted by their agencies' priority for other work (child protection). They do not expect this to change without the appointment of additional staff. Second, the quality of social workers' interventions with disabled children and families is affected by their need to juggle priorities on their caseloads. Because they need to be available for urgent referrals and the crises that develop in their casework they cannot commit themselves to structured or longer-term work in supporting disabled children and families. Again, they consider that this situation will only improve if their caseloads are reduced, or a specialist team created, either of which would require the appointment of additional staff. Third, there is a general lack of confidence among child care social workers regarding their own abilities. This arises largely from inadequate training and insufficient opportunities for practice. This is further complicated by a lack of clarity about the social work role with disabled children, and about the

application of assessment standards, values, and intervention methods that underpin social work with disabled children and families. There are, however, exceptions to this among the specialist social workers and others who have more confidence in their abilities and the distinctiveness of their contribution. Nevertheless, most of the social workers doubt their competence and give little credibility to themselves; and conclude that the work is best undertaken by specialists. Fourth, all the social workers perceive that the lack of investment by their agency in providing sufficient staff and practical resources to meet the needs of disabled children and families adversely affects not just their practice but also their relationships with other professionals. Finally, all the social workers perceive that the lack of understanding from other professionals about their role hinders the effectiveness of their work with disabled children and families. However, they do not consider this, or the collaborative difficulties that they encounter, to be a major obstacle in their work with disabled children and families. Rather, they tend to consider it their own and their agencies' responsibility to do something about promoting their role. Moreover, they conclude that collaborative relationships would be improved, and difficulties largely overcome, if there were marked improvements in their own practice and in the services offered by their agency.

A discussion of these themes in relation to the thesis of social work potential is provided in Chapter 11, which draws together conclusions from this and the next chapter's exploration of other professionals' views about collaborating with social workers.

CHAPTER 8

Attitudes and Expectations: Statement of Results – Part 2

Introduction

The discussions in this chapter, which report on the survey of a wide range of health and education professionals, are informed by their own opinions about interprofessional collaboration and practice in child disability work. The interviews gave these professionals an opportunity to discuss their interpretations of why collaborative difficulties with social workers come about and how they might be overcome.

Like the survey of social workers, the findings in this chapter have particular value because the opinions expressed by respondents are derived from the reality of what their training and experience has given them in the way of understanding social work, collaborative working and practice in child disability work. Their insights concerning these matters are not simply instinctive; they are informed by the personal history of their experience of social workers, training and practice. For some respondents this history covers several decades and they have witnessed many changes. Respondents' opinions, therefore, provide unique insights, which are available from no other source. As with the social workers interviewed, the contribution of these professionals to understanding the phenomena of difficulties in collaborative working is drawn from front-line practice experience, with all the stresses and strains of working life attached. These are the views of teachers and doctors, health visitors and therapists who form their opinions about social workers through their day-to-day work in the care of disabled children.

The chapter concentrates on what respondents' views reveal about the researcher's thesis concerning social work's potential to overcome practice weaknesses and collaborative

difficulties. This examination of findings will show how far the hypotheses are upheld or where the weight of evidence is leading (from which the conclusions are drawn).

The chapter is organised into four sections. The first discusses information collected from health and education respondents about their work with disabled children and their collaboration with social workers. The second section first explores respondents' views on whether social workers appear to understand their roles, knowledge, skills and training. It then considers respondents' knowledge about social work. The section explores respondents' expectations of social workers and considers their views about the knowledge and skills they perceive to be essential for social work with disabled children. This section also discusses respondents' views as to whether social workers make any distinctive or 'unique' contribution to the well being of disabled children and families. This is achieved in part by exploring their perception of what the 'ideal' social worker is like.

The third section considers how respondents have acquired their knowledge about social work and explores their training opportunities on current legislation and collaborative working. The purpose of these enquiries was to discover the impact in practice of the government's emphasis on interprofessional collaboration in legislation and policy.

The final section discusses respondents' observations of change in social work practice and explores their perception of barriers to effective working with social workers.

Section 1: Roles and Perceptions of Collaboration

It was explained in Chapter 6, how respondents were selected for the nature of their work with disabled children and their contact with social workers concerning this. This section first considers the experience of the survey respondents and then explores the structure of the teams in which they work. Consideration is given to where they see social workers standing in relation to these teams. Particular attention is given to the functions of multidisciplinary teams and meetings about disabled children.

Respondents' descriptions of their own roles with disabled children are then discussed and the opportunities they have for collaboration with social workers are explored. This information provides insight concerning how social workers' potential to overcome collaborative difficulties can be restricted if they are not involved in those arenas that other professionals use to plan for and work together in meeting the needs of disabled children and families. Despite most respondents' extensive practice experience with disabled children they report that collaboration with social workers is a rare occurrence outside child protection forums. Moreover, respondents' expressed deep concern about children whom they saw as not receiving an adequate social work service.

A highly experienced sample

The 23 interview respondents had an average of eighteen years in professional practice since qualifying. Only five respondents had less than ten years' experience, while 15 respondents had more than 20 years. No one interviewed was newly qualified. Moreover, all respondents gained their qualifications prior to the introduction of the NHS and Community Care Act 1990, the Children Act 1989 and the Diploma in Social Work.

Among the 40 questionnaire respondents, 18 professionals had more than 20 years' practice experience. Only three respondents had less than ten years' experience, while eleven had more than 30 years in professional practice. Thus, the research findings are based on the opinions of a highly experienced sample of practitioners.

The teams

To get a clear idea of the sort of contact respondents had with social workers, they were asked for more information about the structure and membership of their teams. The team structures can best be described either as 'nuclear' teams, to indicate practitioners working together and/or exchanging information on a regular basis, usually working from the same location; or 'extended' teams to indicate liaison between members as and when required to share information or work together, usually working at a variety of locations. Members of extended teams are often also members of other nuclear or extended teams for other aspects of their work. Teams may also be 'multidisciplinary', indicating that two or more professions work together in either nuclear or extended teams; or 'uniprofessional', where all team members are from the same profession.

Nearly every respondent said that they were members of either nuclear or extended multidisciplinary teams. However, this sense of team identity varied even among professionals working together in the same location. Two teachers, for instance, did not identify themselves as belonging to teams at all. However, another teacher working at the same school referred to a wide range of other professionals whom she perceived as team members, including speech therapists, physiotherapists, visiting teachers, educational psychologists, medical officers, careers officers, support staff and other teachers. This demonstrates how she viewed her work with

disabled children in relation to the other professionals with whom she had contact and whom she perceived to have a key role for the child. Considering this it is significant that this respondent did not mention social workers as team members.

Most health visitors referred to their membership of primary health care teams and/or the 'Child and Family Health Directorate'. This indicated their sense of identity with both nuclear and extended team structures. They reported a wide range of practitioners as nuclear team members within Primary Health Care, including: doctors, district nurses, practice nurses, midwives, community psychiatric nurses, physiotherapists, school nurses and speech therapists. Others, regarded more as extended team members, included child psychologists, chiropodists, community managers, community medical and occupational health officers, counsellors, dental health workers, dieticians, paediatricians, paediatric nurses, practice dispensers, specialist health visitors (children with special needs), specialist health visitors (elderly), teachers and voluntary agency workers and even the clerks and receptionists. Very few respondents included social workers. Only ten of the 40 questionnaire respondents included social workers. Where they were included they usually came some way down the list, perhaps indicating a somewhat peripheral role in the extended team. This interpretation is drawn because generally it seemed that recognition was given to someone as an extended team member if there was liaison between them and the respondent in their work.

This suggests that it was more the work that they viewed as multidisciplinary rather than the team. However, they also included professionals who occasionally used their practice base to do session work, for example, chiropodists and counsellors. This suggested that these workers are perceived as team members by virtue of their involvement in the same field of work, that is, health care.

Among the interview respondents, each of the health and education professionals in the specialist multidisciplinary team for learning disabled children (the nuclear team) perceived the hospital-based paediatric social worker and paediatric physiotherapist as extended team members. This was partly because they were in frequent contact within the same work setting, but also because they identified their relationships to be important in meeting the holistic needs of disabled children. Among the three paediatricians, all of whom worked in the same hospital as the specialist team, only one included the paediatric social worker as a team member.

In total, only a quarter of all respondents perceived that social workers worked with them in multidisciplinary teams, whether nuclear or extended. This lack of inclusion of social workers by health and education professionals demonstrated a low level of contact. Several health visitors and teachers suggested that it would be advantageous for social workers to make themselves more available to the Primary Health Care Teams and schools if they wished to maximise their contribution to disabled children.

Respondents' roles with disabled children

The following discussion considers the roles of respondents with disabled children. This is useful in understanding the wider context of this field of work into which social workers step to fulfil their role. The descriptions also provide an idea of the range of professional interventions that social workers would co-ordinate in fulfilling a key worker role for disabled children and families. Moreover, the findings reveal a range of issues for respondents concerning the role that they consider social workers should fulfil.

Health Visitors

Every health visitor described their primary professional role for disabled children as providing family support. This was referred to variously as: 'Supportive work to family and child - act as family's advocate'; 'Advocate and support for parent and child'; 'Visit as needed to provide support and advice to the family.'

Of those who expanded further on their supportive role, many mentioned 'listening to parents,' and 'making extra visits as necessary.' Seven respondents referred to their role in 'counselling'. Most health visitors went on to mention a role in the early identification of disability as 'screening and surveillance' and 'developmental assessments'. For example, one respondent reported that her role involved:

Support of family; health of child, aiming to assist parents for child to reach full potential. This involves developmental assessments and referrals where appropriate. Support visits are offered to discuss problems, e.g. sibling rivalry, emotional/physical development of a child with a disability.

Another questionnaire respondent gave similar information, describing her role as:

Family Support - parents, siblings, extended family. Developmental assessment. Preventative role: of family network breakdown. Proactive Role: of enabling family to access resources.

Similarly, all the health visitors interviewed described their primary role with disabled children as undertaking developmental assessments and providing parents with advice on child health. Half the health visitors mentioned that liaison with other professionals and agencies for care planning and meeting children's educational needs was part of their role.

Half the health visitors mentioned a responsibility to 'refer to specialists,' such as the health visitor in the children's learning disability team, and the community paediatrician. By this they meant they were required by their agency's procedures to refer any child with a significant

developmental delay to the paediatrician and the specialist health visitor. This was so that further assessment could be undertaken and decisions made about treatment. All the health visitors interviewed expressed positive views about this facility to refer a child with significant developmental delay to the specialist health visitor.

Other responsibilities mentioned included, giving benefits and housing advice; applying for financial help; accessing services; organising intervention to meet families' needs; introducing parents to mother and toddler groups or schools; acting as a link with the health practice; obtaining equipment; promoting continence; and providing information about specific conditions such as diabetes and haemophilia. This is an interesting list, in that it demonstrates a substantial overlap in some areas with tasks that the discussions in Chapter 3 suggested might fall to social workers.

Overall the health visitors' descriptions of their role indicate that they have a broad remit, which is similar in many respects to that of social workers. However, several matters stand out from their responses. First, they report that they do not have enough time to devote to many of these tasks that they consider disabled children and families require. Thus the role described represents an 'ideal' of their professional input rather than the reality. Indeed, the interviews revealed that the facility for them to refer to a specialist health visitor is valued largely because this person is seen to have extra time to give to disabled children and families. Second, in the main their responses are concerned specifically with pre-school age children. Third, some respondents mentioned tasks that they have undertaken, but then suggest that these should in fact be a social worker's role. For example, advice on support services and benefits. Some respondents perceived that social workers were not involved where they perhaps should be because they lacked the necessary knowledge and skills. They considered that social workers

should acquire the knowledge and skills in order to assume responsibility for some of these tasks, for example, providing ongoing support and counselling. Finally, two health visitors expected that social work intervention would follow a more holistic perspective than theirs.

All the health visitors saw their role coming to an end once the child attended school. At this point the child's records are transferred to the school nurse and, with children in school during the working day, they would rarely find opportunities to see the child. This is one reason why health visitors believe that social workers have a key role to play with disabled children of school age, as will be discussed below. Nevertheless, several health visitors pointed out that they would continue visiting if the family needed them, but this was to give support, advice and counselling to parents; the health visitors' role in screening and assessment was no longer required. For example, Mrs E reported that she continued to visit the adoptive mother of a 13 year-old girl with severe physical and intellectual impairments while the child was unable to attend school. The mother had moved to the area with her children to escape violence from her ex-partner and she had not yet been able to arrange education for her daughter. According to this health visitor, the Social Services Department were aware of the family because there had been child protection intervention initially to assess whether the children were at risk from their violent father. However, once the social workers were satisfied that the risk was low, they had withdrawn. The respondent was unhappy about this and stated her intention to continue visiting the family in a supportive capacity. This demonstrates the sort of expectation that other professionals have concerning the role that social workers could fulfil and, in this case, their efforts to plug the gap if social workers do not fulfil this role.

During interview with Mrs P, the specialist health visitor for disabled children, she said that over the six years since the team she worked in had been established, her caseload had

almost exclusively included pre-school children. Her role included counselling parents, particularly at the time of diagnosis, and providing advice and intervention programmes to assist parents in maximising their child's development. She acted as a key worker for families: co-ordinating and organising services, collaborating with other professionals, and providing advice on financial benefits. However, once the children were of school age those with severe learning difficulties were transferred to other members of the specialist team. Children with less severe disabilities may or may not have been referred to the mainstream social services child care teams depending on the child's and families' needs. There was, therefore, no requirement or expectation that these children be made known to the local social services child care team.

Other Respondents

Primary school teachers saw their role as an almost exclusively educational one within the classroom. Although they reported that their policy was to welcome parents and carers to the school, they considered that their ability to offer support and advice was limited because their contact with parents was infrequent. Both primary and secondary school teachers perceived that because their contact with parents or carers was minimal, the social worker could potentially play a significant role in providing advice and support and in acting as a link-person between home and school. This provides evidence of other professionals' willingness to see the social worker fulfil a primary role for disabled children. Respondents' views about this are discussed below.

Miss G, the specialist teacher in the multidisciplinary learning disability team, described her role as 'promoting education'. She promoted the child's learning and progress, and for some children she would take on the role of home-school link. She also provided some parents with

support in making decisions about their child's education, including making herself available to advise them when their child's assessment of educational needs was prepared.

The paediatricians all described their role as concerned with medical diagnosis, assessment and treatment; they also mentioned their role in managing treatments or advising others about them.

The psychologists and speech therapists reported that in addition to their specific role in assessment and treatment, they were also available for consultation by other professionals to recommend helpful interventions for the child. For example, they could advise school teachers how to assist a child with communication in the classroom.

Information about the roles of the physiotherapist, occupational therapist and community nurses is referred to below.

Meetings

Respondents provided information about the meetings they attended to discuss the care of disabled children. This was intended to discover more about their opportunities for collaboration with social workers. The discussions reveal that, other than the specialists, social workers are rarely seen at meetings unless the primary purpose of the meeting was child protection. An interpretation is put forward below concerning the relevance of this.

Planning for disabled children took place in a variety of meetings, including: child development team (CDT) meetings; child care reviews; strategy meetings for planning child protection investigations; annual education statement review meetings; and child protection case conferences.

Mrs S, the educational psychologist, stated that she rarely had contact with social workers at any meetings. Although she received invitations to meetings she did not have the time to attend. Direct work with children is her priority; and she only attends meetings when essential to discuss her work in detail i.e. the statement reviews meetings. This situation highlighted the value of social workers attending these review meetings because they provide a rare opportunity for collaboration with the psychologists.

The teachers mentioned their attendance at the statement review meetings and at CDT meetings. They reported that social workers rarely attended these meetings and, when they were present, it was most likely to be one of the specialist social workers.

Respondents explained that the monthly CDT meeting brought together those professionals who have a key role in the care of disabled children. Parents are encouraged to be present. For pre-school children, the family's health visitor is also invited. Members of the specialist team (learning disabilities) and the paediatric social worker may attend as children on their caseloads come up for review. Respondents accounted for the rare appearance of child care social workers at these meetings by suggesting that, if they had any involvement with disabled children, it was likely to be brief, while the function of the CDT was to review the co-ordination of longer term plans. Consequently, attendance by social workers other than the two specialists was not anticipated. Further comment is made about this below.

For secondary school children the statement review meetings discuss, under the Code of Practice, the preparation of a 'Transition Plan' for children aged 14, where the child's future needs are considered in detail. The teachers explained that this planning process was meant to consider a comprehensive assessment of the child's needs, and should not look solely at their educational needs. However, interviews with three secondary school special needs teachers

revealed that not one of them had witnessed social workers attending these meetings. Nevertheless, they were optimistic that this might change in the future. For example, Mrs P, teacher, understood that an additional specialist social worker was to be appointed to work with disabled young adults; and Mrs G, teacher, said that ‘planning for the future involving other agencies, particularly social services, will have more momentum than it has done in the past.’ These examples again illustrate these professionals’ willingness for social workers to assume a primary role with disabled children.

In addition to the education review meetings and the CDT, the only other forum where teachers had contact with social workers was child protection case conferences. Similarly, paediatricians and health visitors reported having contact with social workers through meetings other than those specifically for planning the care of disabled children, such as child protection strategy meetings and case conferences, core-group meetings for children on the child protection register, and other child care planning meetings. Many professionals experienced these meetings - all essentially about child protection issues - as the only forum in which they met with social workers about disabled children. The focus of these meetings was less about the special needs of these children and their families and more about investigation and assessment of the risk of child abuse or neglect. The significance of child protection interventions for other professionals’ views of social work is discussed below.

The education review meetings and the CDT are both meetings where the child’s plan is considered in detail and yet, while social workers have responsibilities for care plan co-ordination, the findings reveal that they are rarely present at these important multidisciplinary meetings.

Contrast with child protection

In chapter 3, concerns about the lack of social work commitment to disabled children were highlighted. Browne (1982) and Middleton (1996) argued that poor commitment appeared to emanate from a belief among social workers that disability work is uninspiring and that greater satisfaction and status can be achieved in other fields. In consideration of this, it is note worthy that the position of social workers in the CDT and education review meetings contrasts significantly with their position in those child protection arenas where health and education professionals say that they are most likely to come into contact with social workers. In the meetings led by health and education agencies, the social workers' contribution may be considered less significant than others, while in child protection meetings the social work profession leads and social workers carry authority by virtue of their knowledge and powers. Furthermore, their relationships in these meetings are with others who have authority and expertise in their fields: they negotiate decisions and child protection plans with medical consultants, psychologists, solicitors, the police and others.

Considering the issues discussed concerning professionalisation in Chapter 4, the contrast between social work status in the disability and child protection arenas may be accounted for because of the dominance of health professions and the medical perspective in the disability field. Arguably, this can leave social workers uncertain of their position and lacking in confidence. This was evident to some extent in the views of social workers explored in Chapter 7.

The non-appearance of child care social workers at the meetings does not necessarily mean that they are not undertaking work with disabled children and families. However, it suggests that they are not prioritising, or that perhaps they are avoiding, these particular meetings for some reason. It was noted above that the educational psychologists could not attend most

meetings, but this did not necessarily mean that they failed to fulfil their role. However, for social work the discussions of their role and responsibilities in Chapter 3 highlighted the particular importance of their attendance at these meetings because of their primary responsibilities for undertaking holistic assessments and co-ordinating care plans. Moreover, the discussions in Chapter 3 highlighted social workers' responsibility to promote practices and principles consistent with the social model of disability; arguably, attendance at these medically dominated meetings would be essential to achieving this objective.

Opportunities for collaboration with social workers

In order to gain information about opportunities for collaboration other than meetings, questionnaire respondents were asked which social work teams and services they had contact with in the care of disabled children.

Three quarters cited either the specialist team (learning disabilities) or the paediatric social worker. Only four respondents specifically named their local child care team. A further five respondents mentioned simply 'social services', and three named the child protection team. Four health visitors reported that they had no contact whatsoever with social workers regarding their work with disabled children.

These replies also provided insight into respondents' awareness of social workers employed by other agencies and/or working in other services that disabled children and families may use. Only six respondents commented on this: two teachers mentioned the Barnardo's scheme, which employs a team of qualified social workers; three health visitors reported contact with 'voluntary agencies' and one teacher referred to the 'adoption panel'. Not one respondent mentioned social workers employed in respite care services, or the locality social worker

employed by 'Scope' for children with cerebral palsy. Neither did anyone mention the social workers employed in adult services who may be involved in planning for young disabled adults. These responses reveal that while most other professionals say that they have little contact with social workers, they are not really aware of the range of work undertaken by social workers locally and how it links with disability services. This suggests that in terms of social workers overcoming local difficulties in collaboration there may be some value in promoting the breadth of the work that they undertake. This suggestion is discussed further below.

Most respondents were aware that the multidisciplinary specialist team (learning disabilities) could provide social work support for disabled children. However, while health visitors would routinely refer children with significant developmental delay to the specialist health visitor in this team, they only referred for social work if they had concerns for the child's welfare. Thus referrals were not routinely made to social workers for assessment and co-ordination of care planning or for advice and support. The comments of several interview respondents demonstrated their perception that the health visitors' role in the specialist team overlapped considerably with the role they anticipated that social workers would fulfil, particularly in counselling and support.

Questionnaire respondents were asked how much contact they had with social workers concerning disabled children in a typical working week. They were also asked to indicate the purpose and frequency of this contact on a scale that included 'often' (in line with what they might generally expect considering the number of disabled children known to them); 'sometimes' (every now and then, but less often than they might generally expect considering the number of disabled children known to them); and 'never' (see table 8.1 for results).

A quarter of the 43 respondents said they had about an hour's contact with social workers each week. Only three respondents had more contact than this. All the other respondents either had no contact with social workers concerning disabled children or their contact was as minimal as a few minutes a week.

Between half and three quarters of the respondents reported that they were sometimes in contact with social workers to arrange services for families, to request or give advice, or to share information about their work with the child and family. However, more than one in five respondents reported that such liaison never took place; and over half the respondents reported that they never worked with social workers to undertake a specialist assessment, or to evaluate a child's plan.

A significant number of respondents, one fifth, marked the 'sometimes' column for almost all types of contact, although they also indicated that during a typical week they spent no time with social workers either in meetings, in face-to-face discussion, or through telephone contact. This may be seen as demonstrating that their contact with social workers was rare.

In summary, this line of questioning revealed that close collaborative working and liaison with social workers was uncommon for these health and education professionals. Although they may have contact for a limited range of purposes - mainly sharing information about families, giving each other advice, or obtaining a service for a family - they are far less often in touch with social workers to assess the needs of disabled children and families, to collaborate in meeting those needs, or to evaluate the outcome of interventions.

Table 8.1 Reasons for and frequency of liaison between respondents and social workers (percentages)

Reason for liaison	Frequency: often	Frequency: sometimes	Frequency: never
Undertaking specialist assessments.	5	35	60
Providing specialist services to the child and family.	10	67	22
Requesting or giving specialist advice.	5	75	20
Opportunities to share information about each others' work with the child and family.	15	58	27
Working together in preparing a child's individual plan (child care plan).	5	53	42
Having a multi-disciplinary/ multi-agency meeting to prepare a child's plan.	8	60	42
Working together in implementing the child's plan.	5	60	35
Working directly together in meeting the child's and family's needs (i.e. co-working).	3	60	37
Working together in evaluating the plan.	3	47	50

Opportunities for collaboration - opportunities for social work

Interview respondents were also asked about the nature and purpose of their contact with social workers. All the interview respondents said that their contact with social workers was infrequent. Only members of the specialist team (learning disabilities) reported having regular contact with social workers, these being specifically their own team members. Where collaboration had taken place with social workers in other teams, it was reported to have been brief and task-orientated.

Four main themes emerged from the responses of those interviewed, and these provide insight concerning the strengths and weaknesses in social work collaboration and practice in the care of disabled children. First, some social work contributions are greatly valued by those professionals who have received or witnessed them. These are particularly evident in the work of the specialist social workers. Second, most if not all of the respondents want social work to fulfil a role in child disability work - at least the role that they perceive to be that of social work. Third, the lack of contact that they have with social workers, and particularly the lack of response from the child care teams to their referrals, causes collaborative difficulties and has a negative impact on their impressions of social work as a profession. This links with the final theme, which is that in the absence of social work others try to fill the gaps themselves or they look elsewhere to find someone else who can. The following discussion considers the views of different professionals concerning these matters.

Mrs K, a paediatric physiotherapist, reported that as an extended member of the specialist team she had frequent contact with the paediatric social worker and to a lesser extent with the specialist social worker (learning disabilities). She commented that, in addition to her 'hands-on' intervention with disabled children, her role included 'holistic management and counselling.' In

these respects she considered that her role overlapped with the specialist social worker's. She explained:

I mean you've got to manage the child, so you can't just do specific physiotherapy because that's not efficient, you've got to help sort out home situations and support the schools.

Mrs K was positive about the contributions specialist social workers made to the care of disabled children and families, such as emotional support and intervention where she had concerns about a child's welfare (including marital discord or the neglect of children's needs). Mrs K stressed the importance for her of the specialist social workers' contributions by saying that she often reminded other professionals to invite social workers to school reviews and she would prompt them into recognising the social work role. She said that this was often necessary because other professionals could overlook it.

Mrs K also said that she valued social workers as colleagues for the advice and support that they shared with her. She considered that her contact with the specialist social workers was greatly assisted by their being based at the same hospital. Regarding social workers in the mainstream child care teams, Mrs K said that she had only once, in recent years, had contact with them.

But that was more because the school got me involved. I don't think the social worker contacted me much at all - I contacted them... I know who they are, but none of them have ever contacted me. I think there are quite a lot [of families] that do not have anybody, because if problems have arisen and I've said: "Have you got a social worker?" - They haven't.

Mrs K added, 'I suppose the thing is that if they've got someone like 'Mrs P' [specialist health visitor] going in, she is in many ways acting like a social worker.' This point highlights how the roles of health visitors and social workers can overlap significantly, and how they may be seen to do an equally good job. It also demonstrates how some professionals might not

consider it necessary to refer a disabled child and family for social work if the specialist health visitor is involved, or if she can be referred to as an alternative to social work. However, as the descriptions of health visitors' work illustrated, it is only in exceptional circumstances that they continue to support families once the child attends school. Thereafter, the perception Mrs K has is that there are a lot of families who do not have anybody supporting them.

Mrs S, an educational psychologist, reported that for her contact with social workers only took place if a 'significant problem' arose. She stated that 'This is typical of the way of working, it is reactive to problems, not proactive.' She said that contact was nearly always initiated by child care social workers and that it was mainly over child protection issues.

Similarly, Miss G, a teacher, reported that, despite her key role in working with children with learning disabilities, she had very little contact with social workers in care planning for the children. She described the contact as 'not on-going, but related to specific issues of concern.' Miss G anticipated that the level of social work support for disabled children and families might improve. She said 'I am optimistic for the future, and I think that more contact with social workers might become a reality in the future.' This enthusiastic attitude reflected the thoughts of several other respondents who were hopeful that the needs of disabled children and their families were beginning to be realised. Perhaps this was a sign of the respondents wanting to please the interviewer! However, this optimism seemed to be based upon respondents' experience of the specialist social workers, both past and present, and the expectation that the specialist team would be developed further.

The paediatricians reported that their contact with the specialist social workers came about as much by chance as design, because they had neighbouring offices. Despite this, their liaison with these social workers was infrequent. For Dr H and Dr E, the consultants practising

on the children's ward, contact with social workers was limited to those disabled children admitted to the ward, and while on the ward. Dr E was positive about the information and advice that the specialist social workers could provide for her. She valued the information these social workers contributed at CDT meetings, about the child's home environment and family's circumstances, because it enabled her to gain a better understanding about the functioning of individual children and what parents and carers could do to maintain and promote the child's health at home. She also said that she valued the knowledge that the specialist workers contributed about services that might be available to support parents in their caring responsibilities.

The community paediatrician, Dr P, reported that her contact with the hospital-based social workers took place mainly at CDT meetings. Other than this, she had only occasional contact with child care social workers, social service team managers or residential social workers. While she received invitations from social services to attend meetings she did not usually attend. She explained that this was partly because invitations were rarely ever supported through discussion. Rarely did social workers or their managers contact her to discuss what the meeting was about and why they wanted her to attend. Dr P considered that if her attendance was important enough for the child and family, the social workers would conduct this liaison. Otherwise she avoided social work meetings because she experienced them to be 'extremely time-consuming, with lots of people involved, and sometimes the process of decision-making takes many hours.'

Dr P's remarks echoed those of Mrs S, the psychologist who was quoted above, saying that she could not afford the time to attend meetings unless it was essential. These positions suggest that some professionals might find social workers meetings to be somewhat wasteful of

their time. This issue was noted in the discussion of the assertions of Richan and Mendelsohn (1973) in Chapter 4, which highlighted how others can perceive social work meetings as demonstrating social work indecisiveness. Dr P's remarks reinforce the suggestion discussed above, that if social workers are to overcome certain collaborative difficulties then it may be useful for them to attend those meetings that other professionals attend. It also demonstrates the need for social workers to adopt more robust methods of engaging others in care planning.

The more positive remarks of the doctors demonstrate that certain aspects of the social work role are valued. These include their knowledge of services and information concerning those children and families that they know. Likewise, the health and education professionals in the specialist team (learning disabilities) all stated their appreciation of the opportunities they had to discuss the needs of individual children with the specialist social workers. These included knowledge of services and practical resources, but also advice on concerns that they might have about family functioning and/or children's welfare.

Positive remarks about the specialist social workers' contributions in this vein came from those professionals who had regular and convenient access to them - that is, professionals based at the hospital who had opportunities to become more familiar with the social worker's role. However, the findings in Chapter 7 revealed that location and frequent contact do not automatically lead to understanding. The specialist social workers expressed some frustration about the lack of understanding of their role and the lack of close liaison with them from hospital-based professionals, despite their proximity.

Mrs A, a community nurse, working with young adults with challenging behaviour, expressed frustration at the difficulty she faced persuading child care social workers to attend meetings to review the progress of children known to her and the social services department. She

said that social workers were often 'too busy' or 'unavailable.' She perceived this to be avoidance in case the meeting generated work for them. She also thought that inflexibility in their working hours, too much part-time working, and the insufficient number of social workers aggravated this. Mrs A considered it very difficult to adopt a multidisciplinary approach if the assessment lacked social work input. The contribution she perceived the social workers should make were their observations of the young person's home circumstances and how these affected their behaviour and the success of any intervention programme.

Similarly Mrs R, speech therapist, who had 20 years practice experience in the locality, said that she rarely had contact with social workers. She considered that there were many cases where social workers had responsibilities that were unfulfilled. Mrs R gave two examples of cases where she had referred families for social work support but in both cases there was no action taken. The first was for the mother of a disabled child whose husband had died. The mother required support while she was grieving, and she needed help coping alone with the demands of her child. The second referral was for the parents of a teenage boy with learning disabilities who was being harassed by local children; in fact the parents were also being harassed and wanted advice on how to deal with the situation. Mrs R considered that both these referrals required social work intervention, and she was disillusioned by the lack of response.

In contrast, Mrs J, who had qualified more recently, had no expectation that any social workers would be involved with the children she knew unless they had the most severe disabilities, or if there were child protection concerns. These contrasting positions demonstrate how the lack of response from the social work service can cause other professionals to lower their expectations.

However, while the teachers who were interviewed seemed to have lowered their expectations as a reaction to the fact that they had very little contact with social workers, they nevertheless considered social work to have a most important role. The secondary schools teachers particularly thought that the young disabled person's progression into adulthood, and their families' anxieties about it, was a crucial time for social work involvement. Despite the lack of such involvement, the teachers wanted social work to fulfil this role. They considered that the needs of these young adults and their families would otherwise continue to be neglected.

The primary school teachers seemed to have more social work contact than most, although this was mainly from child care social workers monitoring the progress of children on the child protection register. One teacher, Mrs C, said that she was involved in a child protection core-group for an individual child. She said that the social workers did not involve her in care planning, but used her more as 'an extra pair of eyes, to note physical and emotional changes.' Because these children were in need of protection, she was happy to provide these observations, but she considered that care planning could be more inclusive of wider issues for the child than 'protection'.

One Teacher, Mrs W, made reference to the 'social work' undertaken by a member of the specialist team who was actually the health visitor. Mrs W was not confused about this. Her remarks were similar to those of the physiotherapist mentioned above, in that she considered the health visitor undertook a role that she perceived to be social work - that is, she provided families with counselling, support and advice on financial matters, she communicated with the child, made home visits and dealt with matters of concern. Arguably, this demonstrates that the overlap in roles - or what might be described as the deployment of 'multidisciplinary' skills' - can become substantial in multidisciplinary teams, as McGrath (1992) found. However, it might also

indicate that the health visitor was undertaking these tasks because of the lack of social work involvement. This may be another example of professionals filling the gaps in what they perceived to be social work.

Mrs W (teacher) thought that the rare visits of social workers to her school arose from a high turnover of social work staff. She was positive about social workers and happy to welcome them at the school. However, she thought that the regular turnover of social workers made it difficult for her to build up a professional relationship and rapport. Several other teachers stated this concern also. Their contact with social workers was very infrequent. Mrs P said she had hardly had any social work contact in 27 years of teaching. In her current position, it was very rare for a social worker ever to visit the school. Similarly, Mrs D, a teacher at the same school, said that even in child protection cases the social worker rarely contacted them.

Despite these observations, all the teachers interviewed expressed positive attitudes to the research. They returned questions with enquiries of their own, and they were eager to show the researcher the facilities they provided for disabled children. They were all positive about liaison with social workers and they wished that more would visit the school to collaborate with them over meeting the holistic needs of the children attending. This may indicate a belief in the value of the role they anticipate that social workers should fulfil, and their desire to show that social workers would not meet with resistance. This positive attitude was evident in the responses of others who were interviewed respondents. Perhaps it signified the sort of goodwill that other professionals would extend to any social worker who made the effort to collaborate with them. Although it might indicate their wish to please the researcher. Nevertheless, the teachers were very concerned for the young people leaving their schools without adequate support. They were keen to see this matter addressed by social work.

Concerns were also expressed about the lack of social work for other children than those disabled young people leaving school. Mrs E and Mrs J, both health visitors, and, Mrs B, community nurse, were concerned about two groups of children. Firstly, children with special needs whose disabilities were not of the nature and severity that allowed them to access the specialist team, but who nevertheless might benefit from social work; and secondly, those children who did have access to the specialist team but whose 'key worker' was not the social worker. These respondents thought that social work had a role in providing counselling and emotional support, in advising families on how the needs of their children could be met, and in arranging practical support services. They considered this to be a long-term role, which other professionals were not required to fulfil. They visited families with disabled children who did not receive these services from anywhere - and this they perceived was to the families' detriment.

Mrs E, health visitor, gave an example, discussed briefly above, of a mother coping alone with the needs of her thirteen year-old disabled daughter, having recently left a violent marriage. Mrs E considered that both the mother and daughter would benefit from long term support. They had moved to a new area and were not familiar with the community or the support services available. However, despite several pleas to the social services the family did not receive a service. Mrs E said 'it was not for want of trying.' Moreover, she said that this left her feeling 'somewhat disillusioned' and she reflected that she had 'no meaningful contact' with social workers.

Similarly, Mrs J, health visitor, said that the lack of response from social workers had led her wherever possible to make her own assessment of what 'social services' a family might need. She would then try to obtain the services through her own resources. She found making contact with social workers in the locality, and obtaining services from them, to be very difficult. She

contrasted her experience with another area where she had worked, where the health visitors' office and the social work office were in close proximity. This allowed her to make contact easily and to form good relationships with the social workers. Consequently, she felt more comfortable about referring families for support. In her current position, Mrs J said she found the task of liaison so difficult that she had decided to refer only to the specialist health visitor.

The comments of another health visitor, Mrs M, and Mrs B, a community nurse, provide some insight into what it is that these professionals think that social work can and should provide for disabled children and families. Mrs M said that disabled children and families, whatever the extent of the child's physical or intellectual impairments, require 'specialist professional' input. She considered that the knowledge and skills required for working with disabled children and their families required study, experience and dedicated time. Her views elucidated what many respondents meant by the term 'specialism' in social work and this is discussed in detail at the end of section three.

Mrs B, made similar comments, and stated her opinion that social workers have a very important role to play with disabled children and families. She perceived this to be particularly so when there were complex issues that could affect the child's welfare, such as parental drug or alcohol abuse, domestic violence, or the legacy of abuse faced by parents in their own childhood, which can affect their feelings towards their child and their parenting abilities.

Mrs B demonstrated an awareness of the knowledge and skills that social workers could provide for disabled children and families. She had witnessed individual social workers in practice and had respect for their abilities. She remarked that the social work role could be so valuable that:

Sometimes I want to shout "Help!" to the social worker to discuss the concerns with me, and either to act on them, or to work with me in dealing with the issues.

Mrs B praised the specialist social worker in responding to her in these situations. However, she thought differently about the generic child care social workers. She said that they undervalued her work and ignored her referrals. She thought that even when families and other professionals were 'desperate' for a social worker's assistance it was not forthcoming. Mrs B gave an example of this. She described a case where she had been asked by the social services to assess urgently a child with attention deficit hyperactivity disorder. On completion of the assessment, she referred the case back to the social services, advising that the child and family would benefit from a range of social work services. Her advice was underpinned by some concerns for the child's welfare. However, no action was taken. Mrs B said that she knew that the social services had a responsibility under the legislation to provide services. Consequently, she made further referrals both verbally and in writing. Still she received no response. Mrs B said that she had to ask her manager to intervene. The manager did so in writing, but received no reply. Mrs B said that she concluded from this that social work intervention was only forthcoming when situations reached such a level of concern that child protection procedures needed to be invoked. She commented that she understood that child care social workers carried onerous responsibilities for child protection, which placed great demands on them and on social services' resources. However, she argued that this should not be used to justify an inadequate service for disabled children. She concluded that 'Social workers have excluded disabled children because of prioritising others - like child protection cases.'

Summary

The comments of these respondents have demonstrated that, despite their lack of contact with social workers and the low level of social work intervention with families known to them, they nevertheless consider that social work has an important contribution to make for disabled children. The contribution they envisage is concerned with emotional support, provision of services and intervention where there are concerns for the child's and family's welfare. It also includes providing information and advice on these matters for other professionals. For some respondents this perception of what social work can, and perhaps should, provide is based on their observation of the practice of the specialist social workers, whose work they admire. It may be argued, therefore, that the work of the specialists provides evidence of social work potential to overcome collaborative difficulties and practice weaknesses.

The next section explores respondents' opinions about whether social workers' collaboration with them demonstrates a sufficient understanding of their role with disabled children. The section also explores respondents' understanding of the social work role and seeks to clarify what, if anything, they consider distinctive about this role.

Section 2: Understanding Roles

In exploring the roles and responsibilities of social workers in Chapter 3, it was shown how current legislation recognises that the welfare system has become so complex that families require help to make their way around it. It was also shown that families often experience frustration in dealing with so many professionals, each apparently contributing something different and valuable for their child - yet apparently without effective liaison with one another. Families face uncertainty about who to contact for any particular aspect of the whole. Moreover, they often do not know where one professional's contribution ends and another begins.

Chapter 3 also established that current legislation envisages that disabled children and families would be able to obtain the assistance of a care manager to co-ordinate their assessment of needs, and to pull together all the resources required to meet those needs, including the contribution of other professionals. This role recognises that families face heavy demands in caring for disabled children, and that it may be helpful for them to contact someone, with the right mix of knowledge, skills and values, to assist them in co-ordinating the services they require - thereby relieving them of some of the pressures. This co-ordinator is not expected to know and do everything, but is required to know about the work of others. This section discusses respondents views about whether social workers know about their work. It also considers what respondents know about social work. The survey reveals that despite the exhortations of legislation, most professionals perceive that their role is not understood by social workers. The section explores the collaborative difficulties that this causes. The survey also finds that respondents themselves lack much knowledge about social work, although they generally do not consider that this creates any significant problems for collaboration.

Social workers' understanding of others' work

Questionnaire respondents were asked three questions to ascertain whether they perceived their role to be sufficiently understood by social workers for the purposes of effective collaboration. In regard to each question, respondents were asked to indicate whether they considered social work understanding to be impressive; sufficient; insufficient or wholly insufficient. Although several respondents set conditions on their replies, by indicating that understanding varied widely among individual social workers, overall their responses indicated that they think social workers do not know enough about their work.

The first question asked 'In your contact with social workers do they have sufficient knowledge about your role and the particular contribution you make to a child's plan?' Just over half the respondents thought that social workers had 'sufficient' knowledge in this area, though none found it to be 'impressive'. The remainder, almost half, thought social work knowledge was 'insufficient'. More than 10 per cent of respondents thought that social workers' understanding was 'wholly insufficient'.

The second question asked 'Do you feel that social workers have sufficient understanding about your professional knowledge, skills and value base?' Three quarters of respondents judged that social workers' understanding was 'insufficient' (65%), or wholly insufficient (10%). Only a quarter of respondents thought that social workers' understanding was 'sufficient', and none of them were impressed.

The final question asked 'Do you feel that social workers have sufficient understanding of your professional training?' As with the previous question, three quarters of the respondents thought that social workers' knowledge of their training was either 'insufficient' (65%), or

‘wholly insufficient’ (10%). Only a quarter of respondents considered that social work understanding was ‘sufficient’.

The interviews provide some insight into health and education professionals’ opinions concerning these matters. Regarding social workers’ knowledge about her role and training, Mrs S (educational psychologist), thought that the knowledge of any other professionals about her role had lessened during the previous decade because of the substantial changes in policy concerning the assessment of special educational needs. Social workers, she thought, were no different in this respect and could not be expected to have much understanding of her role. She commented that ‘even the schools - the Heads - have difficulty understanding.’ She thought that inter-agency training would be useful in addressing this problem.

Neither of the speech therapists thought that social workers understood their work. However, Mrs R said she found it difficult to comment with certainty because of her minimal contact with social workers.

Similarly while some of the teachers had come across social workers with the necessary understanding, all of them felt that it was generally lacking. The teachers considered it important that social workers should have an appreciation of their role. However, Miss G thought the responsibility to enquire about each others’ roles was equal. She did not think that social workers understood her role, yet she was mindful that despite a lengthy career in teaching she did not know enough about social work.

I haven’t ever really been quizzed by any social worker about what my professional background and experience has been. But I don’t say that disparagingly because conversely I’ve never questioned the background of any social workers really, on a professional basis. (Miss G.)

Mrs D, a secondary school teacher, considered social workers' understanding of her role to be insufficient. She thought that they lacked an appreciation of the challenges and demands that teachers face working with disabled pupils.

Certain social workers tend to be idealistic: they've not got their feet on the ground, they don't take a practical approach and they don't really consider the views of teachers or others. (Mrs D.)

Mrs D concluded that practitioners should improve their understanding of each other by taking opportunities to get together outside formal meetings to discuss their work more broadly. Several other teachers thought that even where social workers had some understanding of their role, the nature and scope of their work could not be fully appreciated unless social workers visited the school.

Mrs L argued this point strongly. She had worked for more than twenty years in special education. Her current teaching role included preparing programmes for independent living and behavioural intervention for pupils who had not been able to manage in other special schools. She considered that social workers could not possibly understand her role because their contact with her, the school, and the pupils was almost non-existent.

Similarly, Mrs V (occupational therapist), said that she had identified a distinct lack of understanding about her role on the part of social services staff, and she considered this to be a significant problem. The sorts of problems this caused were that social workers made inappropriate referrals, and sometimes expected her to take on tasks that she thought were their responsibility.

Similarly, Mrs T, health visitor, said that while she thought social workers generally understood her work, there was a lack of clarity about the role of a health visitor that sometimes led to social workers expecting her to do work that was not really her responsibility.

Well, I don't think it's a very clear definition myself, so I take things on which I've thought wasn't to do with my work, and I wish that I hadn't, but the social worker didn't want to do it! What I'm trying to say is: that I don't have a very black and white definition of what my job is, there is a whole lot of areas where it does overlap [with social work]. (Mrs T.)

Most of the health visitors and community nurses surveyed thought that social workers' understanding of their role varied, but was generally poor. Mrs M, health visitor, said that she did not know what social workers would learn about health visitors during their training, but health visiting had changed enormously in recent years, both professionally and locally. She considered that understanding about the roles of other professionals is something that is built up over time, through experience, and that social workers would need to keep up with change.

Another health visitor, Miss N, said she doubted whether social workers realised the extent of professional experience and training that nurses needed before undertaking the Certificate in Health Visiting. She added:

When I did the health visitors' course in 1987 there were a lot of social workers in attendance, as you do some of the sessions with them - a multidisciplinary thing - yet there were a few who had no idea what we did at all, and there's still a bit of that now! (Miss N.)

Mrs E, a health visitor, explained how difficulties can arise in collaboration if social workers lack understanding of her role. She complained that social workers often saw her simply as a 'home visiting nurse,' with responsibility for children living in unhygienic circumstances, or children for whom there were concerns about neglect. Mrs E considered at times that social workers only viewed her role in terms of its value to them in child protection assessment.

The community nurses, Mrs B and Mrs A, reported that although they had occasionally met knowledgeable social workers, their experience generally was that social workers had a very poor understanding of their work.

Social workers don't appear to know the depth of knowledge, or the wide range of areas you are trained in as an RNMH [community nurse mental handicap]; or the fact that you concentrate almost exclusively on caring and educational experiences for people with a learning disability. If you look at the nursing syllabus and compare it with the DipSW a lot of things are so similar in where they are aiming, but where the social work course is ranged across the whole population, in learning disability nursing you concentrate on one small group, and go into immense depth. (Mrs A.)

Mrs A also reported that her training had not been based wholly upon a medical model: the social valuing of disabled people was a key aspect of her training. She stated that 'sometimes social workers can express surprise when they do find out what is involved.' Moreover, she thought that social workers sometimes 'undervalued' the range of practical skills that she had in her nursing repertoire.

Mrs B likewise reported a feeling of being undervalued, and even threatened at times, by social workers who did not appreciate the breadth of her knowledge. Her comments demonstrate how the lack of understanding can create collaborative difficulties. She said that at times social workers would not accept that her assessments of clients' needs were skilled and informed. Consequently, as 'gate-keepers' of services, they would insist on doing their own assessment, which duplicated work and could frustrate families.

In contrast to most respondents, Miss F, an art therapist, thought that the social workers with whom she had had contact did seem to understand the purpose and value of therapeutic intervention. In fact, she considered that perhaps their understanding and appreciation of her work was better informed than most other professionals.

In conclusion, respondents' experiences lend weight to the findings of other commentators that practitioners consider that social workers insufficiently understand their roles and the nature of their work. The survey has revealed how this lack of understanding can create collaborative difficulties and affect other professionals' perception of the competence of social

workers. In summary, these problems include: inappropriate referrals; others perceiving that their opinions and assessments are disregarded, or that social workers do not appreciate the purpose of their involvement; and other professionals sensing that social workers are avoiding their responsibilities by expecting others to do work that is really theirs.

Respondents' understanding of social work

Questionnaire respondents were asked three questions concerning the adequacy of their own understanding of social work roles, training, knowledge, values and skills for the purpose of effective collaboration. They were asked to indicate whether they considered their understanding to be: comprehensive; sufficient; insufficient or wholly insufficient. The first question asked: Do you feel that you have sufficient knowledge about the role and particular contribution which social workers make within planning and provision of services to children with disabilities and their families?

While one respondent had an impressive understanding of social work training, which she acquired through personal contact with friends undertaking the DipSW course, other respondents were less sure of their knowledge in this respect. Only one in five respondents (20%) considered that their knowledge of the social worker's role was 'sufficient'; and not one reported that they had a 'comprehensive' knowledge. All the other respondents (80%) thought their knowledge was either 'insufficient' or 'wholly insufficient'.

The second question asked: Do you feel that you have sufficient understanding about social workers' knowledge, skills and value base? Only one third reported that their understanding in this area was 'sufficient'. The rest of the respondents considered their understanding 'insufficient'.

The final question asked: Do you feel you have sufficient knowledge of social work training? Four out of five respondents reported that their knowledge of how social workers are trained was either 'insufficient' or 'wholly insufficient'.

These findings support previous reports concerning the lack of understanding professionals have about each other. The researcher thought that 'wholly insufficient' might be too strong a phrase, and that perhaps professionals would not want to admit to such a level of deficiency in their knowledge. However, their use of this category may be interpreted as indicating the seriousness with which they regarded their need for information and improved collaboration with social workers.

To explore their knowledge about social work training a bit further, respondents were asked, both in interviews and the questionnaires, to name the basic professional qualification for social work and the length of training; and they were asked if they knew what post-qualifying training social workers could undertake. Respondents were also asked whether they thought that the training period for social workers was sufficient and if they knew how long social workers spent in practice placements.

One third of the questionnaire respondents (17) named the 'Certificate of Qualification in Social Work' (CQSW) as the current professional training. Three respondents gave variations such as, 'CSQW', 'NQSW' 'SQSW'. Three other respondents copied the researchers' own qualification details from the front of the questionnaire. Three respondents, two teachers and a health visitor, reported that they did not know what the qualification was or anything else about social work training.

Twelve respondents thought either that the qualification was degree level, or that a relevant degree was required before post-graduate training. Only four respondents, all health

visitors, named the current qualification, the DipSW, while a further six simply wrote 'diploma'. It can be concluded, therefore, that the move from CQSW/CSS to DipSW training in 1991 was not widely known among other professionals.

Nearly all respondents thought that social work training required two or three years study. Half the respondents thought this period was sufficient. However, a quarter of the respondents thought that the training period was insufficient. The remaining respondents (10) indicated that they did not know, or did not have an opinion on, whether the period of training was sufficient.

A small number of respondents (6) thought that the training took four years and that it entailed a degree and postgraduate qualification; they all considered this to be 'sufficient'.

Some respondents made comments on their questionnaires that suggested they considered social workers to be inadequately trained. One health visitor reported that the sufficiency of the training period 'depends on the individual and their life experiences.'

Discussions with the interview respondents found that two-thirds (16) of them were unable to name any social work qualification. Most of them thought that social workers would study for a degree before completing a two or three year postgraduate certificate. Of the 23 respondents interviewed only one health visitor and a community nurse were aware of the change to DipSW; the source of their knowledge was reported to be from close friends who had recently undertaken the course.

Interview respondents' knowledge of the time social workers spent in practice placements varied considerably. Nine respondents could not hazard a guess. Four thought that about a quarter of the training period was placement-based. Seven respondents thought that at least half the training time would be placement-based. Two others believed it to be nearer three-quarters, and one paediatrician thought that a full post-graduate year was spent in placement.

These findings demonstrate a wide variation in knowledge about social work education and training. The interviews with the health and education professionals provided some insight into how their perceptions of social work training were formed, the source of their information, and their views about what level of education and training is required for social work qualification.

Mrs P, teacher, reported feeling somewhat embarrassed at not knowing anything at all about social work training, knowledge, skills or values. Nevertheless, she hazarded a guess that the duration of study was about three or four years - and she supposed that this was necessary for the following reason:

In order to - there is so much in the news recently about how much social workers have not followed-up cases. Is it lack of training, or too much to do? I know you can't train social workers for everything. Course content is important. Looking back on my teaching course, it was not of great benefit really. You need to be a particular type of person and to use your own initiative.

Mrs V (occupational therapist), considered it essential that social workers undertake at least degree level education, in order to 'keep on a par' with other professionals. She considered student placements to be particularly important for learning about collaboration as it allowed time to be spent with other professionals and insight to be developed concerning their roles. Similarly, Mrs D, a teacher, said that social workers should have a placement in a school, in order to observe pupil behaviour and 'the problems that teachers face.'

Among the paediatricians, Dr E had no idea what the social work qualification might be, or the level of academic study required. Neither could she guess what the course content might be. She supposed that three years training would be available, and she imagined that social workers would undertake some study in a 'specialism'. Interestingly, Dr E was unconcerned about her lack of knowledge. This she explained was because she had managed to get by, and

she learnt what she needed to know about social workers by ‘asking for the wrong thing and then being put right!’

Similarly, Dr H concluded that she knew nothing about the social work qualification, the course content or the duration of study. She guessed that social workers would undertake basic training in communication skills, before taking a specialist option. She thought only those social workers who had chosen a child disability option and undertaken specialist training in child health and psychology, would work with disabled children.

Dr P thought that social workers qualified with a degree, which required three years academic study and two years practice study, with half the practice time being spent in work placement. Dr P thought that specialisation in social work, and training focused on the needs of particular client groups, including disabled children, would be provided by employers through in-service training.

In summary, the majority of respondents thought that social workers receive two to four years training to achieve professional qualification, and nearly 30 per cent understand this to be a degree or post-graduate qualification. This appears to contrast with the findings of other commentators that other professionals perceive social workers to be insufficiently qualified. However, the discussions in Chapter 5 concerning social work training identified that there also seems to be a fairly common view that initial social work training, despite its length, does social workers little good because they leave college without the relevant knowledge, skills and maturity. Considering this matter, and the initiatives that the social work training body, CCETSW, had taken to address criticisms, the researcher explored also respondents’ knowledge of the post qualification opportunities available for social workers.

Post-qualifying training

More than half the questionnaire respondents reported that they did not know what additional training social workers could undertake after qualifying. Seven respondents suggested that a degree, postgraduate diploma or further degree in social work could be undertaken after qualification. Only six interview respondents suggested that any further training might be available, (and none of these were aware of CCETSW's post-qualifying awards).

Other respondents were aware that social workers could supplement their knowledge and specialise through employment-based training. The following specific training was assumed to be available with the number of respondents who mentioned it: child protection/abuse (8); child care and special needs (7); care of elderly/adults (6); mental health (6); probation (2). The following areas were also mentioned, although each only by one respondent: specialist training in alcohol and drug abuse; social work for deaf and blind people; social work with disabled people; fostering and adoption; management; law and court procedures. One respondent referred to professional courses, conferences and workshops.

The questionnaire and interview responses revealed a general uncertainty among health and education professionals about what additional or specialist training social workers could undertake after qualification. However, the substance seems to be that somehow specialisation takes place and that the training for it is in the main employment-based in-service.

Summary

The results provide insight into respondents' expectations and perceptions of social workers as 'qualified professionals' in terms of the education and training required for such status. Most believe that social workers have a university degree and post-graduate education,

although 80 per cent conclude that they do not know enough about this. Furthermore, although many of them hold the opinion that social workers who undertake work with disabled children should have 'specialist' knowledge and skills, most respondents do not think that this is provided within social work qualifying training. However, these professionals have little idea about from where such knowledge would be acquired. Although some respondents were aware of 'in-house' courses they (accurately) thought that these entailed only two or three days' training. Other respondents supposed that social workers would learn the knowledge and skills necessary for particular work while actually doing the work - that is, through practical experience rather than training. Thus many respondents thought that social workers learnt 'the basics' in college before 'real work' enabled them to specialise. None of the respondents mentioned any other methods by which social workers could develop their knowledge and skills, and none of them were aware of the post-qualifying awards.

It was established in the first part of this chapter that half the interview respondents either worked with social workers in multidisciplinary team structures or they were able to contact social workers conveniently in their work settings. The finding of their lack of knowledge about social work is, therefore, all the more interesting. Arguably, this demonstrates that while multidisciplinary team structures and physical proximity may encourage the development of interpersonal relationships between professionals, it does not necessarily facilitate understanding between them. This supports Challis's (1988) observation that simply placing different professionals together will not equip them with knowledge of each other, or with collaborative skills.

'The Essential Social Worker'

The purpose of the enquiries detailed in the following discussion was to discover respondents' views about the knowledge and skills that they considered most important for social work practice with disabled children. Their responses also provide further insight into their understanding of social work. The enquiries also aimed to discover whether respondents viewed social work as contributing anything unique, or at least distinctive in this field.

In Chapter 3 it was established that Barclay (1982) considered all professionals to have responsibilities to promote respect for their clients' dignity and worth, but that social workers carried a 'prime responsibility' for this. It was also established that other commentators, including Browne (1982), Middleton (1996) and Morris (1997), suggested that social workers carry a prime responsibility for advancing the social model of disability. The enquiries aimed, therefore, to discover whether respondents judged that social workers fulfilled such responsibilities.

The questioning also sought to discover whether respondents discerned that the practice of social work required a synthesis of knowledge, skills, values, training, and experience that is particular to the profession. Butrym (1976) considered 'efficiency' and 'reliability' to be key defining features of professionalism, and hence it was necessary to consider whether respondents might attribute these to social workers.

Skills to fulfil the social work role

In Chapter 3 it was concluded that other professionals, who are familiar with the Children Act 1989, may consider it reasonable to expect social workers to be competent in a wide range of knowledge and skills, such as carrying out holistic assessments of need in partnership with

parents; knowing how various disabilities can affect a child; undertaking individual social casework and family casework; supporting foster carers; communicating with disabled children; counselling; identifying useful resources and services; and undertaking child protection work. They might also expect social workers to advance children's rights and promote mainstream services; and to be knowledgeable about the roles of other professional workers.

Enquiries to health and education professions revealed differences in expectations according to profession. The health visitors' replies varied most significantly from other respondents. This was largely because they deal mainly with pre-school children and answered questions from that perspective: few health visitors gave responses that looked beyond the child's infancy. Similarly, teachers and psychologists mainly considered the needs of school-age children. The community nurses, specialist health visitor and other health-based therapists all had broader outlooks, while they also focused largely on what the social worker meant to them in their work, rather than what the social worker might mean to the disabled child and family throughout childhood, and across and beyond the various professionals' particular contributions.

The eight areas of knowledge, skills and values that the 63 respondents cited most frequently as required by social workers to fulfil their role are listed below with the frequency of citation in brackets:

1. Knowledge of services and resources (44): including specialist, voluntary, national and local organisations; respite care; nursery/day care facilities; holidays and equipment.
2. Counselling skills (42): including communication, listening and interpersonal skills; interviewing skills and methods; skills in caring and providing on-going support.
3. Knowledge about social security benefits and other disability allowances (22): including skills in giving financial advice.

4. Knowledge about family dynamics and relationships (20): understanding the problems which families face when raising a disabled child.
5. Knowledge about childhood disabilities (20): including basic knowledge of disabling conditions, some specialist knowledge of particular disabilities and some medical or nursing background.
6. Liaison and team work skills (19): including knowledge of other professionals' roles.
7. Knowledge of legislation and social policy (19).
8. Knowledge about normal child development (15).

This summary reveals that some key aspects of the social work role were mentioned only infrequently, or not at all, by a majority of respondents. This may lend some weight to the findings of other commentators in the field concerning the lack of understanding about the social work role. The summary shows that less than one third of respondents considered it essential for social workers to have skills in counselling and knowledge about childhood disabilities, family dynamics and the roles of other professionals. It is important to consider before examining the findings in more detail, that respondents might not have thought to mention certain areas of knowledge or some skills because they took it for granted that these would be commonplace and expected. This may have particularly been the case for questionnaire respondents with limited time to answer the questions. However, the use of different research methods gave the researcher the opportunity to interrogate these matters further. During the in-depth interviews many respondents had considerable difficulty suggesting what knowledge skills and values were essential for social workers to fulfil the role that they perceived them to carry. Many respondents gave up suggesting anything much after a simple list and admitted to some embarrassment about their ignorance.

Other than the areas cited in the list, ten respondents mentioned that social workers required knowledge in psychology, and six mentioned the need for knowledge of child abuse and skills in child protection work. The low frequency with which these matters were mentioned may be interpreted as indicating that respondents thought that counselling, family work and child protection were distinct specialisms that social workers learn after qualifying. Alternatively, it might be that respondents assume social workers have these elements as routine parts of their training. However, the findings in the previous section, concerning professionals' knowledge about social work training, suggests that this might not be the case.

Other areas that were cited by less than five respondents included skills in: advising parents on behaviour intervention/management; assessment; report writing; interviewing; consultation; co-ordinating services; life-history work; direct work with siblings and young disabled adults; fostering and adoption; representation and advocacy; and designing services. On a more theoretical front, less than five respondents mentioned the following: politics; race and anti-racism; equal opportunities; studies of community and society; understanding of systems theory, group work dynamics and psychodynamic theories.

Somewhat surprisingly, considering the subject of this research, only one respondent, a health visitor, thought that knowledge about the work of other professionals and the skills required for collaboration might form a part of social work training. However, it may be interpreted that respondents consider that the knowledge and skills for collaboration would somehow be acquired through work experience.

As suggested above, the low frequency with which respondents mentioned some specific aspects of social work training may be accounted for by the limited time available to complete the questionnaire. Seven questionnaire respondents (five health visitors; a speech therapist and a

psychologist) gave succinct descriptions of those areas of knowledge and skills that they considered essential for social workers, in responses that displayed insight into the range of needs with which disabled children and families present. However, analysis of the questionnaires indicates that most respondents selected just two or three areas of knowledge and skills, which were perhaps those that they considered most important. Responses varied across the eight areas cited above, but it seemed that the weight given by respondents to child development, knowledge of support services and counselling skills, reflected the fact that most of the questionnaire respondents were health visitors and, as suggested above, that they think in terms of the role that social workers might fulfil with pre-school children.

A significant number of very experienced health visitors (8) gave striking opinions in the questionnaires about specific skills and qualities that they considered essential and fundamental for social work, but elsewhere in the questionnaire they indicated that social workers lacked these attributes. Their opinions and the range of other responses are discussed below in highlighting further respondents' perceptions of social work.

Six questionnaire respondents, three teachers and three health visitors, did not answer questions about the knowledge and skills that they considered essential for social work with disabled children. Analysis of their other responses shows that each reported that their knowledge about social work was 'wholly insufficient'. Remarkably, one of these respondents who had 33 years' experience as a nurse and health visitor, reported 'I feel I have insufficient knowledge to comment on this.'

Three interview respondents, a teacher, a paediatrician and a therapist, were also not even able to suggest what areas of knowledge and skills might be essential for social work practice.

Most other interview respondents struggled to identify more than a few fundamental issues. For example, Mrs K (physiotherapist) remarked:

Blimey, I don't know, I haven't really thought about it. I suppose there's an element of psychology - I see an important part of their role as supporting families. They must have a practical side to them, because I think they've got to follow up all the leads to get all the various financial supports... it involves going around charities, it's really a begging situation at times.

Among the questionnaire respondents who gave replies that displayed knowledge of social work training were the following three examples. A psychologist divided her response into three sections, which showed an understanding of the breadth of social work training.

Clinical: understanding family structures, dynamics and adaptive/maladaptive interactions - Nature and effect of disability on individual and family - Specialist counselling skills (Psychotherapeutic, cognitive behavioural) - Assessment of need - Abuse: its consequences, implications and treatment.

Organisational: understanding service networks - Statutory, Private, Voluntary.

Legislation: Government documents, Children Act, Mental Health Act, array of benefits (Questionnaire respondent).

A health visitor gave a similar response though with a greater emphasis on communication and collaborative skills.

Understanding of the effects of disability in general, and specifically with regard to the individual child. Good communicator - with the child, family and other professionals.

Advocacy skills. Knowledge of benefits, and statutory and voluntary organisations.

Teamwork skills - working together to plan and implement care (Questionnaire respondent).

Another health visitor reported a comparable opinion, but in simpler fashion, emphasising some more personal attributes, which she thought were essential for social workers working with disabled children.

Knowing the effects of disability in a family; knowing the importance of liaison with other professionals; interpersonal skills are a must; full knowledge of

benefits and services available; a genuine interest in the job; counselling skills (Questionnaire respondent).

Those who recorded a short list of skills and knowledge cited most of the same areas as these three examples, while limiting their list to just two or three specific matters. For example, one respondent expected social workers to have knowledge and skills in 'normal child development, allowances and housing provision.' Another anticipated knowledge of 'family dynamics and educational provision and choice.' A third respondent expected 'good interpersonal and communication skills and confidentiality between professional colleagues.'

The emphasis in most of the questionnaire responses rested on a combination of child development, knowledge of services and interpersonal skills. As suggested above, these responses could be interpreted as portraying only that which respondents believed to be most important. However, they might also demonstrate a lack of knowledge or low expectations about social work knowledge and skills. One interpretation is that these professionals are well aware that social workers receive a college-based training. Many respondents will have come across social workers during their own time at college, perhaps even attended joint seminars with them. They may also know from discussions with social workers they meet that they have degrees and diplomas. However, they may not know much about what the social workers actually study. The fact, identified in this study, that they have very infrequent contact with social workers means that they have few opportunities to find out what knowledge values and skills social workers bring to their work. Perhaps those respondents who provide more insightful answers to these enquiries have had more personal or professional contact with social workers than most. The interview responses, which are examined next, suggest that this is the case. Arguably, other professionals, as some of the responses detailed below appear to demonstrate, think that whatever

social workers might learn in college or on employment-based training courses will be of little relevance if they do not respond efficiently, effectively and with maturity to referrals. Thus, as suggested in Chapter 5, the credibility of training is likely to be measured by social workers' performance rather than by the content of their training.

Some evidence to support this interpretation can be found in the responses of eight health visitors, each of whom had between 15 and 39 years' nursing and health visiting experience. Three of these respondents simply wrote that the essential knowledge and skills for social workers were 'practical knowledge and work experience.' And each of them also wrote that there was 'insufficient' evidence of maturity, experience and counselling skills among social workers.

The responses from a few of these experienced health visitors displayed not only low expectations, but also indignation and resentment. For instance, five of these respondents, who considered it essential that social workers have communication skills, practical knowledge and work experience, also reported that social workers' knowledge about their roles, knowledge and skills was 'wholly insufficient'. One health visitor judged that social workers were insufficiently skilled in 'using a holistic approach in assessing family needs' and that they were 'failing to communicate their role and contribution to clients.'

These respondents' comments suggest that they have long-standing grievances concerning social work. They also suggest that these observations are not limited solely to social work for disabled children. They do not appear to believe that social workers are capable of fulfilling the role that they expect of them. In some respects this challenges the researcher's thesis that social workers have a potential to provide expert services to disabled children and their families. After all, these comments and concerns are provided by some of the most

experienced professional practitioners within community health and education. Their remarks provide further evidence, adding to the sources identified in Chapter 4, that the practice weaknesses in social work are so long-standing that there is little reason to think that the situation will change markedly. Browne (1982) was concerned that if something was not done to address weaknesses the role could be lost.

However, it could be that the lack of knowledge these respondents have about what social workers do, and how social workers' ability to do more might be restricted for various reasons, may cause these respondents' view to be distorted. Either way, the evidence exposes social work weaknesses - it is not seen to be efficient and effective, competent or professional, by these very experienced practitioners. Moreover, although they appear to know little about social work training, their comments suggest that it has little credibility in their eyes.

Some more light can be shed on these matters by examining the views of those respondents who were interviewed. The interviews provided the researcher with an opportunity to delve deeper with respondents to explore why they perceived particular areas of knowledge and skills to be essential for social work practice with disabled children. This was achieved in part by asking them to describe their 'ideal' social worker. As with the interviews with the social workers the researcher anticipated that this question would allow the 'ideal' to be compared and contrasted with the reality of social work practice that respondents experienced. This line of questioning revealed much about how respondents perceive their relationship with social workers, and how certain matters can create collaborative difficulties. The discussion also brings out their perceptions about certain aspects of the social work contribution that might be considered distinctive or unique. These are summarised in a discussion at the end of the section. The views expressed by respondents highlight several themes. First, that different aspects of the

social work role are considered essential and appreciated by different professionals. Other professionals seem to focus on what social work means to them (and the families that they meet) in the context of their work alone. However, this seems to lead to narrow expectations concerning the social work role.

Because of this, others may not identify the social worker as appropriately skilled for a given task even though they may be well qualified and experienced. Nevertheless, the research finds that respondents base their views essentially on practice experience. Thus, whether their experience was of a narrow social work role, or a broad social work role, this is what they came to expect. Second, there are some 'sting in the tail' views expressed by some respondents, who identify knowledge and skills as essential for social work and then suggest that social workers do not really have these, or that they do not use them effectively, or that other professionals (including themselves in some instances) could do the tasks just as well.

Finally, the positive views of the contributions made by the specialist social workers provide evidence of social work's ability to overcome practice weaknesses and collaborative difficulties.

The discussion is organised under sub-headings that highlight the particular area of knowledge and skills that respondents considered to be most important for social work with disabled children and families.

Knowledge of services and resources

Mrs J, a health visitor, considered it essential that social workers have a broad knowledge of the services and resources available to support disabled children and families. Her reasons for this, however, were not straightforward, and the interview was helpful in revealing the sting in

the tail and in exposing the frustration that lay behind this opinion. Mrs J said that if a social worker was working with a family struggling to cope with a disabled child, they could access certain services because they work for the agency that is responsible for these services. However, if she identified the need for the same services she faced considerable difficulty accessing them - she would have to refer to the social services. This she found very frustrating and perceived it as indicating a 'devaluing' of her role and skills. She considered that the social services were using social workers as service 'gatekeepers'. The situation as she saw it did not really require a social work assessment, just the service. Hence, while Mrs J considered social work knowledge of services to be essential, the sting in the tail was that she thought their assessment often superfluous because they should accept hers (or that of other skilled professionals).

Dr E also considered that knowledge of services and resources was essential for social work. Her 'ideal' social worker would be someone who was willing to find out about facilities available for families. She included in this home adaptations, washing machines, and information about and access to services. Despite her wealth of experience, and her key position for disabled children, Dr E admitted to having little knowledge about social work. She viewed social workers essentially as 'information-providers' to families on the availability of practical services. She commented:

The social worker is an 'overall' person, they are better at liaising - social workers tend to be a bit of everything. I take them as they come...if I ask for something and it's not the social worker's role or job they let me know! I learnt about social work by asking for the wrong things, and then by being put right (Dr E.).

Dr E's position suggests that significant aspects of the social work role can be overlooked - that the social workers' broader contribution might not be called on when otherwise indicated. Thus other professionals might not make families aware of other potentially helpful social work

services. They might only refer families whose needs meet with their ideas about social work intervention.

Mrs C, teacher, also thought that social work knowledge of resources and services was most important. However, she was critical of the fact, as she saw it, that some families got plenty of support services from social work, while others got little or nothing. She remarked that those families who 'shout loudest' or those who 'know the system' (including some receiving services for 'child protection' reasons) seemed to get services where others who are deserving have failed. Mrs C considered that social workers needed to achieve more equity in service provision, by being available to support many more 'special needs' children and families.

Counselling Skills

Several respondents mentioned the importance of social workers having counselling skills and providing families with emotional support. Mrs M, health visitor, thought that social workers received better, 'more specialist training' in counselling than health visitors. She said that if a social worker could offer these skills and visit disabled children and families frequently this would constitute a most valuable contribution. There was something of a sting in the tail here, however. Mrs M thought that social workers were better placed to do this work than health visitors because of their smaller caseload. However, she did not witness them providing the support as envisaged. This had led her to conclude that all disabled children should have access to 'specialist' social work input. She considered that the increased specialisation and expertise provided by the specialist social workers was an important and positive change in social work practice in recent years, however, she thought that it was not far reaching enough.

Exploring this further, Mrs M said that it was not so much the ‘specialist knowledge’ that specialist workers provided that was significant, as the fact that they offered a ‘dedicated service’. She thought the child care social workers were ‘too focused’ on child_protection work, and that they would need even smaller caseloads if they were to give proper support to disabled children and families. Other respondents whose views are examined at the end of this section echoed this view.

Some of the teachers also considered that social workers have an important role to play in offering counselling and support to families. Mrs W considered ‘Who else is there once the child is in school and the health visitor has withdrawn?’, suggesting that the social worker was more important for school-age children (over five) because the health visitor has withdrawn and teachers have only minimal links with the child’s home. All the teachers attached importance to social workers taking a role as a link between the child’s home and school and this will be examined in detail below under liaison and team working.

Miss G, teacher, conceived counselling in a broad sense, including support for the disabled child, their parents, carers and siblings and extended family members, and she considered that for social workers ‘Counselling and supporting is an intrinsic part of their work.’ Miss G stressed the importance with which she regarded the social workers’ role in direct work with disabled children who are fostered or adopted. She also considered counselling and support to be crucial matters when social workers arranged accommodation for children, whether this was short-term such as respite in the event of a crisis, or long-term because of serious family difficulties. Miss G commented that social workers have a role in:

Supporting school-age children where there are a variety of problems - domestic problems - especially for older children who exhibit school phobia or who may be truanting on a regular basis; then I think they - the child and the family - need time to talk with the social worker.

Miss G was among just three respondents who considered that social workers have a role in 'early counselling' for parents when a child's disabilities first become evident - whether this be at or around the time of birth, or later when developmental delay or other indicators of special needs lead to a diagnosis being made, and to specialist services and support being required.

There was some uncertainty among respondents about the level of skill that social workers brought to the counselling role. Miss G was exceptional in attributing a high level of skill to social workers and in her high expectations of them. More generally, despite two-thirds of the questionnaire respondents indicating that they considered counselling or 'listening, communication and interpersonal skills' to be essential social work skills, many respondents expressed opinions that such skills were 'insufficiently contributed' by social workers.

This may be interpreted as meaning either that there was not enough counselling available, or that the social workers were not considered to be good enough at it. The interviews provide some insight into this, and both these interpretations are borne out. Respondents reported that social workers were either not responding to referrals and hence not giving counselling and support as requested, or they undertook short-term intervention only and then withdrew. The interviews also revealed more about what respondents understand by the term 'counselling', and it is revealed that for most respondents it is not the skilful matter which Miss G portrays, or which was suggested by one questionnaire respondent who considered that social workers should possess: 'specialist counselling skills (psychotherapeutic, cognitive, behavioural).'

Several health professionals commented on the difference between 'proper counselling' and the sort of supportive, unobtrusive listening and communicating which they attributed to social workers. For example, Dr H described the ideal social worker as being 'A counsellor, as

well as a social worker, in the general sense - not as a qualified counsellor, but their role should be perceived as someone there to help rather than to impose on them.'

Mrs V, occupational therapist, considered that social workers had a 'unique role' in 'monitoring family structure' and by virtue of this role they would be 'aware when things appear to be breaking down.' However, Mrs V did not consider social workers to be particularly equipped to help the family if things did break down. She considered that their counselling role might entail addressing family difficulties 'if they are able and qualified to do so, and if the family do not want to be referred to a psychologist...' But otherwise, she considered that the social worker would need to refer to a 'skilled counsellor'.

Mrs V considered that the social worker's role in counselling overlapped with that of several other professionals - health visitors, occupational therapists and doctors - and that counselling was in fact a specialist role in itself, with the necessary skills really being the property of a 'counsellor', not a social worker. Social workers, she remarked, 'counsel their clients regarding their needs for benefits and services.' Mrs V explained that as a part of her specific intervention she may give some counselling to a client, but she would not be in a position to offer on-going counselling, so she would bring it to the attention of the social worker as a 'need' that the client has, whereupon she considered it became the social worker's role to find the right 'other' person to meet that need. In her opinion the social worker's task therefore lay in assessing the need for services and in exploring the alternative services available for the family, it is not for them to provide a counselling service themselves.

Mrs V's position is similar to Dr E's discussed above, in that it displayed limited expectations and did not take account of certain aspects of social work that require skilled counselling and informed intervention. For example, in dealing with such matters as drug or

alcohol abuse, psychiatric illness, violence in the home, parental learning disability, child protection, early counselling, direct work with disabled children and their siblings, family or group work.

Hence, the level of skill attributed to social workers in support and counselling is belittled and, as suggested above, referrals are unlikely to be made to social workers by professionals who hold narrow ideas about their role. However, there is also evidence that some professionals form low expectations because they do not hear accounts of social workers undertaking skilled counselling.

Knowledge of benefits and finance

One-third of respondents (22) reported that knowledge of financial benefits and grants was essential for social workers. The interview respondents' expectations were that this knowledge would be used to practically assist families in obtaining financial resources. Some respondents identified this as a unique contribution that social workers make, though this seemed to arise more because no-one else undertook the task rather than because it required professional knowledge and skills.

For example, Dr H considered that the social work role could be divided into two main areas. First, understanding family dynamics and providing resources to help and second, helping with financial arrangements. In her opinion the social worker was seen to uniquely contribute:

A lot of practical things, in terms of needing help with grants and financial arrangements - that side of things I would certainly feel that I didn't know enough about, but somebody needs to deal with it.

Mrs V, occupational therapist, who had frequent contact with the specialist social workers considered that the 'ideal social worker', making a 'unique contribution' would be one who possessed:

A broad understanding of the benefits and allowances available for families, who would assess clients' needs for benefits, including home care services, taking a holistic approach during their assessments of clients' ability to cope.

Similarly, Mrs J considered that one of the social workers' unique contributions was that 'Social workers have specific skills in organising grants and finance.'

Knowledge of family dynamics and relationships

It was discussed above how most interview respondents believe that social workers learn something in their training about the impact on families of caring for a disabled child, so that they can offer appropriate support. Nine of the interview respondents considered that social workers had a role in carrying out assessments of 'family problems'. Four of these respondents considered this a particular social work skill, because they observed that social workers should consider the 'whole family' and assess their 'holistic' needs. This was contrasted with the roles of other professionals who undertake specific and focused tasks, which are often with the child alone as, for instance, with speech therapy and education. Respondents' expectations however, were that social work involvement would largely be 'problem-focused': that they would deal with crisis situations, child protection and other domestic and family problems.

A further six respondents remarked upon the key role social workers have in child protection. Miss G considered that the social workers' unique professional contribution was to be found in the skills they possess in informing families of concerns 'which other professionals would maybe be reluctant to face.' She reflected that:

There are times when social workers - and I think that this is the stress of their work - have to confront parents with their concerns about their child which other professionals would say: right, refer it to the Social Services. It is then the social worker who has got to have the honesty and integrity to confront people with suspicions or allegations which other people could or would avoid.(Miss G.)

Mrs S, psychologist, also considered social work skills in dealing with family problems to be most significant. In contrast, she did not consider advice on benefits, finances and services to be an area of social work that required particular comment. Instead she considered that the social work role in making 'an objective, professional in-depth assessment of the family's problems was of much greater importance. Mrs S considered that the 'ideal social worker' would have:

Insight into family dynamics and the child's world - from a professional perspective, that is: informed by knowledge; one who takes a problem-solving approach and considers the family's perspective, while being confident of their own professional perspective.

The unique contribution that Mrs S thought social work made was to be found in the skills and knowledge that they applied in gaining 'detailed and in-depth background information about the family which can be useful in helping the child.'

This reference to the social history as a social work tool, which can describe the disabled child's home environment and family circumstances, was considered by several professionals, including teachers and therapists, as most valuable to them in their assessment (and treatment) work. It enabling them to understand more about the child and therefore be more effective in helping them. The issue being, that social workers were considered able to gain access to the family home, and hence to be in a position to provide observations about the child's family circumstances and their behaviour and abilities at home.

Mrs W, primary school teacher, commented that 'The school could be more understanding of the children if they know what is going on at home.' However, she felt that some social workers did not appreciate the value of this as they would not share their

observations because of 'confidentiality'. Mrs L and Mrs D, secondary school teachers, also expressed opinions that social workers could be helpful in making 'professional and objective assessments of families' problems if they then shared that information with teachers so that they could be aware of the sort of problems impacting upon the child at home - problems which the family might not be willing to share with the school themselves.

Understanding childhood disabilities

Most respondents thought that social workers would learn something about the impact that having a disabled child would have upon the family, and the type of support needs that they might have as a consequence.

Six respondents expected that social workers would learn about the common types of physical or intellectual impairments and the psychological effect of them on the child. Four respondents considered that social workers have a role to play in assisting carers to develop parenting skills, or in advising them on behaviour management.

Mrs D, teacher, expected that social workers would learn about disabled children through a practice placement in an appropriate environment such as a special school. Among the respondents Mrs D was exceptional in this respect, and also in her expectation that social workers would develop skills in interviewing children with special needs during their qualifying training.

In contrast, nine respondents thought that social workers would not learn about children with special needs unless they had specialised after qualification. For example, Mrs J, speech therapist, thought that there would simply not be enough time during basic training. Mrs C, teacher, considered that, as with teaching, knowledge regarding special needs would be an 'extra area for special study.' Dr. H, and Dr E, also thought that social workers would need to

undertake 'special options' after 'basic training'. Miss N, health visitor, also expected that knowledge about disabled children would require some additional specialist training, though she remarked that in her experience social workers had a good knowledge of the relevant matters.

Mrs T, health visitor, stated that it was difficult to know whether social workers had knowledge regarding the special needs of disabled children because:

As with all the disabled children I have had on my caseload, they haven't had social workers... One disabled child whom I was visiting was allocated to the specialist health visitor [in the multidisciplinary learning disability team] and I think that she's done a lot of work that might be the social worker's role.

Skills in liaison and teamwork

Nearly all the interview respondents emphasised how important it was that social workers understood their respective roles, and that there was effective liaison with them. Many respondents mentioned how current legislation had increased the emphasis on collaborative working. What was interesting to discover was what these professionals expected social workers to collaborate with them over. This was interesting because it provided more information about their expectations of social workers, which in turn revealed more about their perception of the social work role. Furthermore it allowed them to express their observations about the co-ordination of services for disabled children and the role they consider social workers should play in this. Moreover, it revealed areas that they thought could be improved.

All the health visitors and community nurses commented in various ways that they should be able to expect an efficient response from social workers - and an early discussion about any referrals which they had made to the social services. They expected that feedback should be given on the outcome of any intervention that had been initiated through their referral. Furthermore, they considered that if social workers had contacted them for information about a

child and family then the purpose of social work involvement should be shared with them and they should be given feedback. These matters were considered particularly important when professionals had a continuing role with the child and family. However, all respondents remarked that these practices rarely took place. Another respondent stated that she has often referred what she considered to be 'a significant social problem' and found out later that less action was taken than she expected.

In the opinion of teachers and psychologists, the social worker should ideally act as a link between home and school - providing the school with information and observations about the child's family circumstances, their behaviour and leisure activities - and they should particularly support disabled adolescents in their transition towards greater independence. All the teachers emphasised the importance of this despite rarely witnessing it taking place. Mrs L, for example, remarked that she had worked closely with the specialist social worker concerning a teenager with extremely challenging behaviour and she had found the collaboration to be very helpful. However, she observed that this was a 'one-off'. The remit of her school had altered shortly before the interview, and the changes meant that most of the children who now attended no longer fulfilled the criteria for referral to the specialist team (learning disabilities), consequently most of them had no social work input. However, Mrs L was aware that child care social workers were involved with some of the children, and that child protection concerns were being monitored. Yet she found that the social workers rarely if ever made contact with her or other staff in the school. Mrs L said that there was definitely a role for social work with all the pupils at the school because they all had disabling conditions and challenging behaviour, which affected their social opportunities and future careers. Moreover, their behaviour caused stress for their parents and other family members. In some cases the standards of parenting for the children

were unacceptably poor. Mrs L considered that there was therefore a three-fold role for social work with these children: in supporting the children and their families; in co-ordinating other support services and exploring social opportunities; and in monitoring any concerns about parenting. In Mrs L's opinion, this would constitute the role and unique contributions that social workers could make, and yet she rarely witnessed this taking place.

The secondary school teachers expressed similar views. They remarked upon a plan which they believed to be in progress within the social services to appoint another specialist social worker specifically to work with disabled school leavers. They were enthusiastically looking forward to this.

Several respondents were clear that having specialist social workers facilitated good collaboration and liaison, and they proposed that this was the only way that a multi-disciplinary approach could be achieved in providing services more broadly for disabled children, because the mainstream child care teams were so hampered by their child protection responsibilities. This was evident in Mrs B's remark quoted earlier that 'Social workers have excluded disabled children because of prioritising others, like child protection cases.'

Mrs J, health visitor, contrasted social workers' collaborative skills in child protection - wherein she observed there to have been significant developments in recent years - with the limited input for disabled children. She observed that while collaborating with social workers as a member of a 'core-group' for a child on the child protection register that:

There was a very different attitude to how we dealt with that. It was much more structured - you do this bit, I do that bit - we evaluate what's going on, we meet up again. There is much more! (Mrs J.)

Mrs J saw this as evidence of social work skill and professionalism, while regretting that it was not more widely available for those children with special needs who could not access input

from the specialist social workers, and with whom she had observed there to be minimal social work involvement.

Conclusion

Respondents' views generally reflected their own experiences of social work within their practice contexts. Few discussed how social workers might need a wide range of knowledge and skills to equip them for various roles. Some respondents praised social workers for skills that they witnessed arising from the efforts of individuals, most notably the specialists. This seemed to lead them to consider that if disabled children and their families required social work intervention it should be from a specialist - who had specialist training. Overall, the expectations of social workers varied significantly. While some respondents considered social workers capable of expert intervention, others had narrow expectations even of the specialist workers.

The following discussion explores those areas of knowledge and skills that respondents considered essential for social work practice with disabled children and families, but which they perceived to be insufficiently in evidence in their experience.

Essential, yet inadequate

After detailing the areas of knowledge and skills that they considered essential for social work with disabled children, questionnaire respondents were asked to indicate where, in their experience, social workers' knowledge and skills might be insufficient. Many respondents (17) did not answer this question, and analysis of their questionnaires revealed that most of them had indicated elsewhere that their understanding of social work was 'insufficient'. Three respondents reported their opinion that social work knowledge and skills were 'sufficient', and one

respondent (a speech therapist) reported 'I actually have a very high opinion of the social workers whom I have met.'

However, many health visitors expressed concerns about a range of skill deficits. Six reported that social workers had insufficient skills in counselling: three considered that social workers lacked sufficient maturity and experience.

Six other health visitors reported that social workers needed to improve their skills in collaborative working. For example, Mrs Y wrote that social workers need 'to be clear as to why they want information, and return with outcomes of situations to health visitors and other colleagues.' Similarly Mrs P wrote that social workers need to possess an 'awareness that other professional colleagues are working under pressure as well as themselves.' Another health visitor, Miss S, wrote that '[Social workers] do not understand urgency, and they do not act on referrals as we would like.'

Some other skills that health visitors identified as lacking among social workers included the use of a 'holistic approach' in assessing families' needs, and a 'failure to communicate their role and contribution to clients.'

Regarding essential knowledge, one health visitor, Mrs W, reported that social workers lack knowledge about disability generally. Another health visitor, Mrs V, considered that social workers had insufficient medical knowledge, which she considered 'essential and sometimes overlooked during assessments of need.' Other respondents mentioned specific areas where they considered social work knowledge to be inadequate, including: funding sources; child development; mental health; the Children Act and the roles of other professionals. Not only health visitors reported concern about social work standards in these respects. Two teachers

considered age and appearance to be important matters for social workers. One of them, Miss K, wrote:

Informality and a very 'laid back' approach can cause an aura of lack of structure and strength on which some parent need to rely. There must be a mutual respect from all agencies and parents involved. This is sometimes difficult with very young "hippy" type social workers. Many parents around this area are older 'farming type' people who fail to relate to very 'way out' clad social workers.

The other teacher, Mrs J, held a similar opinion. She thought that 'normal child development, allowances and educational provision' were the essential areas of knowledge and skill required by social workers in providing services to disabled children. However, she wrote:

I often find social workers very informal and casual which often makes it difficult to be detached from parents, causing lack of respect on a professional level. This can sometimes give the appearance of a lack of structure and demeans the role of social workers. I feel that parents must be respected, and that all professionals must command respect in return - first name terms do not seem to achieve this.

These findings reveal that at least half the questionnaire respondents consider that social workers lack sufficient understanding in some fundamental areas. However, some comments suggest the prevalence of somewhat stereotypical views about social workers.

The Distinctive Contribution

The discussion of the knowledge and skills others perceive to be essential for social work, reveals something about that which they perceive to be distinctive in the social work contribution for disabled children and families. Considering the importance that other commentators have identified of professionals having distinct and distinctive roles the researcher made further enquiry to respondents concerning this aspect of social work. Questionnaire respondents were asked to record whether they thought social workers offered anything 'unique' to this field of

child care. Interview respondents were asked the same question and their perception of an ‘ideal’ social worker was discussed.

One third of questionnaire respondents (13) did not answer the enquiry. This may be because they did not think social workers contributed anything distinctive. Two respondents wrote that this was their view. Perhaps others found it difficult to describe distinctive aspects of the social work role. Three respondents wrote that social workers made a unique contribution, but they did not describe it. All the other questionnaire responses (22) suggested distinctive contributions in three main areas of social work: knowledge of and access to services; skills in counselling and support; and statutory powers, which gave social workers unique responsibilities. Some respondents’ comments suggested that they considered social workers capable of making distinctive contributions in a range of areas. Each of these matters is explored separately in the discussions that follow. The purpose of discussion is to identify what precisely respondents thought was unique about these contributions from social work, and whether their comments suggest that they perceive the contributions to be those of a ‘professional’.

Unique knowledge of and access to services

Mrs S, (psychologist) thought that social workers fulfil an important role in co-ordinating services. However, she thought other professionals could also do this work. Thus she argued:

Social Workers should be well, though not uniquely, placed to co-ordinate service provision for children and families; and to fight for the funding necessary to meet identified service deficits.

Most health visitors considered that the distinctive contribution of social workers lay in their skills in providing and arranging services. Some of these were straightforward matters such

as arranging 'Child care provision'; 'Social security benefits knowledge'; 'Ability to be a source of knowledge, particularly for resources and benefits.'

Some respondents considered that the distinctive component of the social work contribution was that they fulfilled their agencies' responsibilities to provide services. Comments included: 'They have departmental financial contributions to make and can help by providing family aides'; 'Social Services hold the budget'; 'If a child has special needs social workers are in a position to put pressure on different agencies to provide the necessary help.' Thus it was the agency responsibility that was distinct, rather than the social worker's skills in fulfilling them.

However, other respondents thought that social workers did fulfil their role in distinctive ways. For example, Mrs J, speech therapist, considered that the ideal social worker would be 'a friend, but with powers to help, who is available for the family at the end of a phone.'

Social workers have specific skills in organising grants and finances... Social workers have got legal powers.... Social workers can monitor family structure and be aware when things appear to be breaking down... Social workers are more generally able to assess family needs.

Mrs R (speech therapist) said that the only distinctive contribution she considered social workers offered was benefits advice. For her, an ideal social worker would be one who responded to her referrals. However, despite her evident disillusionment with social work, she considered that social workers 'might possibly have a role supporting older children.'

Mrs V, occupational therapist, also thought social workers made a unique contribution through their ability to assess clients' need for benefits and home care services. Her ideal social worker would have a broad understanding of the benefits and allowances available.

Similarly, regarding the distinctive contribution of social work, Dr H said:

I had to know this for postgraduate training. You were meant to know the social work role - the social security and disability benefits which you can request that the social worker helps with.

Counselling and Support

Four questionnaire respondents, two health visitors and two teachers, thought that counselling and support were distinctive social work contributions. They commented that social workers had more time for these tasks. Mrs K, physiotherapist, said:

I see the social worker as the person trying to actually support the family through some of the basics, to be the person that they can off-load onto who has got the time to actually sit, because if I'm going in I've got therapy to do as well.

Mrs M, health visitor, also thought that the social workers' unique contribution arose from their 'ability to visit more frequently and to provide support services.' Mrs M emphasised that she was referring to the specialist social workers.

Miss F, therapist, considered that the right personality was crucial in social work. In her experience social workers used to 'come across as crusading rather than facilitating.' Now, however, she thought that many social workers had developed skills in listening and facilitating, and that they were aware 'that people are not problems to be solved.' Similarly Dr H considered that the personality and approach of social workers was important. An ideal social worker would be seen by families as 'someone there to help rather to impose on them.' Someone who brought 'enthusiasm to the job.'

Mrs J considered that the ideal social worker would be 'warm and compassionate with a good understanding of the family.' She viewed the social work role with disabled children as distinct from other social work roles: 'Social workers have a supportive role, with services behind them. The social work role is supportive not policing.'

Legal powers and responsibilities

Some health visitors (5) considered that legislation gave social work distinctive responsibilities. Comments in this vein included: 'They have a special role which gives them much authority'; 'They have statutory duties for the child'; and 'they have a working knowledge of the Children Act'. Miss G, teacher, thought that this aspect of social work was distinctive. She considered that social workers possessed particular skills in informing families of concerns that other professionals are reluctant to face.

Mrs E, health visitor, had worked in a multidisciplinary team for disabled children in a different county, and she had gained insight into the social work role through this work. Considering her experience, she thought that the level of social work intervention with disabled children in the locality was disappointing. She thought that child care workers were nearly always busy with child protection work. However, she concluded that their key responsibility and contribution lay in their 'authority under law to remove neglected or abused children.'

A mixed bag of contributions

Other responses demonstrate that some professionals perceive social workers to have distinctive contributions to make in a number of different areas. The following comments, made by questionnaire respondents, serve as examples: 'Specialist social workers in this field develop an in-depth knowledge of the problems faced by families of a child with disabilities'; 'Planning the future for children, in the long-term where necessary'; 'Specialising in social needs in community and hospital etc.' and 'An advocate for children and families - someone from outside health'

Mrs S, psychologist, considered that the distinctive contribution made by social workers was their:

...ability to gain detailed and in-depth background information about the family which can be useful in helping the child... The educational psychologists' role is often based on a limited assessment, while social workers can have insight, which is objective from a professional perspective.

Mrs S went on to comment that for her the ideal social worker would 'have insight into family dynamics and the child's world, from a professional perspective - that is, a perspective informed by knowledge.'

Similarly, Dr P considered that social workers could make a unique contribution to disabled children and their families.

I do very much see them as having a unique contribution. A lot of people don't see a difference between health visitors and social workers. The social work contribution is in helping the family to help the child, rather than in directly helping the child - except with older children when this may be useful. (Dr P.)

Summary

The perceptions of these other professionals demonstrate wide views about that which is distinctive about the social work contribution. The reasons for such variations are difficult to fathom. Some of the most experienced and senior practitioners in health and education had remarkably low expectations of social work, which did not reflect a perception of social work as a 'profession', let alone a profession with equal status as them, and ready to take a leading role in the collaborative care of disabled children. However, some respondents' experiences suggested to them that social workers 'could' and in some cases were making important and distinct contributions. These were manifest in the work of the specialist social workers and also in child protection. Several respondents' comments demonstrate that it is in the efforts of these workers

that they witness the sort of structure, collaboration and evaluation that they expect from competent and professional practice.

Interested to know whether respondents thought that these distinctive contributions were supported by theory, values and research - and considering the emphasis in social work training on the importance of theory and values being explicit in multidisciplinary practice - the researcher enquired to interview respondents whether they perceived social workers to make use of theory and guiding principles in their work. This enquiry also allowed the researcher to hear whether other professionals witnessed social workers promoting the social model of disability in their assessments and interventions.

Theory and philosophy

Most respondents said that they were not conscious of social workers using theory in their work with disabled children. Some stated that their contact with social workers had been insufficient to comment. A few respondents answered the enquiry as though theory was the same as college-based learning - none of these said that they witnessed social workers using theory to inform their practice.

Miss N, health visitor, remarked that neither theory nor 'direction' were explicit in social work. However, she thought that social workers were developing the use of models and theories.

I'm sure they know what they are aiming to do, but I don't think they always share that information; and maybe it's a fault on our side as well - that we don't sit down and talk about it. (Miss N.)

Dr P, paediatrician, considered that the use of theory should be reflected in social workers' assessment reports. She thought that social workers should make known their theoretical perspective when presenting their opinion of the family's situation in

multidisciplinary meetings. However, she said that she rarely witnessed this taking place. Generally she found social workers to be 'woolly and long-winded'. She also considered that social work philosophy was synonymous with resource availability. She commented that 'Social work philosophy is practised when resources permit.'

Similarly Mrs C, teacher, expressed concern that 'Social workers tend to be like psychologists in taking everyone's view; and then they waffle. They are insufficiently direct.' Likewise, another teacher, Mrs D, remarked that social workers 'tend to be idealistic and unworldly.'

Mrs A, community nurse, viewed these matters somewhat differently. However, her position was derived largely through observation of social work practice with disabled adults rather than children. She thought that social workers made a unique and valuable contribution as 'the champion or advocate of the oppressed.'

She commented that social workers help people through the welfare system, help them to get services and to sort out their benefits and housing problems. They help people get things that they are entitled to, but which they would struggle to obtain by themselves because of the obstacles and the complexity of bureaucratic systems. Thus, Mrs A considered that social workers use their knowledge and skills to uphold the rights of vulnerable people.

The individual social workers that I've worked with, and attended training courses with, have all struck me by their egalitarian libertarian approach to work: everyone is equal, and everybody deserves that chance - and you cannot impose something on somebody just because of the condition that they find themselves in. This does shine through quite strongly among the social workers you meet....' (Mrs A.)

Nevertheless, Mrs A remarked, in similar vein to Dr P, 'Whether, when it comes to the practical hands-on, they are able to devote time to putting that into practice I don't know.'

Similarly, Miss N, health visitor, thought that sometimes social workers looked at things from a different perspective. She considered that the specialist workers had time to focus on disabled children, and consequently that they provided a more in-depth service and they gained valuable expertise. However, she thought that each member of the specialist team had these advantages, regardless of their professional background. Miss N considered therefore that the distinctive contribution of any team member lay in the subject area within which they developed particular skills. For example, the health visitor advising on child development, the nurse advising on behavioural intervention, and the social worker undertaking counselling. More generally, Miss A considered that what differentiated social workers from the other professionals was that they 'approach things from a different angle - not a medical angle; and because of this the family would see a different side to things.'

These respondents' observations and expectations of social workers were different from most other respondents. They do not view the social work role as simply providing families with information about benefits and services in a sensitive manner. They identify other important reasons for social work involvement. These relate to an alternative perspective and a responsibility to uphold people's rights - perhaps informed by, though not named as the social model of disability.

Section 3: Information about Social Work and Interprofessional Collaboration

The following section explores how respondents learn about social work and interprofessional collaboration. Respondents were asked whether their training addressed collaboration and the social work role, and whether they had studied or received training on the Children Act and the Community Care Act. The purpose of these enquiries was to obtain insight into how professionals learn about social work.

Questionnaire respondents were asked to what extent their training had examined multidisciplinary working and interprofessional collaboration in child care. They were asked to indicate whether this had been 'in detail'; 'sufficient'; 'insufficient'; or 'not at all'.

Half the respondents reported that their training had either been 'insufficient' or that they had received 'none at all'. All other respondents (20) reported that their training had been 'sufficient'.

Among the questionnaire respondents, only health visitors had opportunities to look at the social work role during their qualifying training. Nine health visitors had attended joint lectures with social workers in sociology, child development or child abuse; four had participated in seminar discussions with social workers; four had attended lectures by social workers in child protection work; and three had spent time with social workers on placement. The health visitors interviewed provided more information on what this training about social work entailed.

Three of the six health visitors interviewed said that they had attended joint lectures or seminars with social workers, but they doubted the value of these for learning about collaborative working. For example, Mrs P said that despite health visitors and social workers sharing some course modules, little time was spent examining each others' roles. She remarked that 'everyone thought there should be more opportunities.' Similarly, Miss N commented that although she

attended shared lectures with social workers there was little contact with them otherwise, and so they remained ‘somebody over there somewhere.’ Mrs T, health visitor, was concerned about the lack of opportunities to explore other professionals’ roles. She said: ‘I’ve never done any sort of training about what social workers do or what their job is. It’s assumed that people know.’

Mrs E, health visitor, remarked that her opportunity to learn about social work was distinctly unhelpful. The roles of other professionals were not explored at college; and the only opportunity she had to learn about social work was a placement day spent with a social worker. She said that this was a very negative experience for her because the social worker was ‘lazy, unprofessional, unsympathetic, and did not earn his money!’

Few of the other interview respondents had received any training about social work or collaborative working. Mrs J, speech therapist, said that there was a strong emphasis on multidisciplinary working and liaison during her qualifying training, but this was more about ‘not working alone’ than understanding others’ roles. Mrs V, occupational therapist, was the only respondent whose qualifying training included several interprofessional components: multidisciplinary lectures, a presentation by a social worker, and a written assignment requiring students to describe the roles and contributions of other professionals in carrying out a ‘home assessment’.

Ten respondents commented that they had discussed professional roles and collaboration at joint workshops in child protection, and during training on the Children Act when it was first introduced.

The comments of interview respondents suggest that they did not find attending lectures and seminars with other professionals to be an effective way of equipping them with the knowledge and skills required for interprofessional care. Lectures presented by social workers

on child protection provided them with little information about the broader roles and contributions of social workers. The focus was on the identification of child abuse and the process of investigation.

Questionnaire respondents were asked about their main sources of information about social work. Two-thirds (25) mentioned contact with social workers in work. Comments included: 'Social workers met in the course of casework'; 'Direct contact with social workers'; 'Just knowledge from people I have worked with'; 'Telephone liaison and families' impressions' and 'Personal contact'. One third of questionnaire respondents (14), all health visitors, reported that a major source of information about social work was their attendance at child protection and Children Act training and planning meetings.

Other main sources of information about social work that questionnaire respondents mentioned included: the health visitors' qualifying course; contact with students during training (6) and friends or family who are social workers (3). One respondent commented that reading health visiting literature was a source, and another stated 'general reading.' One respondent mentioned 'the media.'

Most interview respondents reported that reading and contacts in work were their main sources of information about social work. Miss N commented upon her lack of understanding about social work when working in hospital settings, and she remarked:

I think I became more aware of social workers when I came out of the hospital environment, which makes sense I suppose, but I do think you still need to know [about social work] even if you work in a hospital.

Miss N had attended group discussions in a different locality with a range of professionals for the specific purpose of exploring each others' roles. She said that these meetings had been very helpful and her knowledge of social work bore witness to this.

Many respondents thought that information about social work should come from social workers. They considered that their lack of understanding about social work was due to their lack of contact with social worker. Other sources of information they considered less helpful and reliable. One respondent commented 'if there were more social workers actively involved with disabled children, I would expect to learn more about the profession.'

Children Act and child protection training as sources of information

Nearly all respondents said that they had received in-service training on the Children Act for between one and three days. Most of this training was arranged by the Social Services Department when the Act became law in 1991. However, most respondents remarked that their training had not addressed the needs of disabled children and it had not served as a source of information about social work. Two teachers said that the practice implications arising from the Children Act for disabled children were covered during study for the Diploma in Special Education.

The majority of respondents considered training about the Children Act and child protection to have been a major source of information about social work. However, the training neglected to consider the needs of disabled children. Thus respondents have received little opportunity to explore the social work role outside of child protection work. This training has, however, emphasised the importance of interprofessional collaboration and provided practitioners with opportunities to learn more about each other. The training established a foundation for working together in child protection.

Section 4: Changes in Social Work Practice and Collaboration

This section explores respondents' opinions about changes in social work practice in the locality, either as a result of reorganisation or legislation. The section also discusses their views about problems in collaborative working and how they might be resolved. The purpose of these enquiries was to discover whether respondents perceive improvements that could be developed further by social workers to overcome collaborative difficulties and practice weaknesses in child disability work. Conversely, the researcher was also interested to know whether professionals judged that any changes had been to the detriment of child disability social work or collaborative working.

Questionnaire respondents were first asked whether they had observed any improvements or decline in social work knowledge, skills and practice with disabled children during their professional practice; and second, whether they had observed any changes in social work with disabled children as a direct result of recent legislation and policy, or because of local initiatives. Interview respondents were asked similar questions, though more specific enquiry was made concerning their views on social workers co-ordinating multidisciplinary interventions (in the light of the Community Care Act and the Children Act). All respondents were asked for their opinions about what created barriers to effective collaboration with social workers and their views on how these might be resolved.

Practice changes

The following quotation from Mrs S, educational psychologist, reflects the views of many concerning changes in social work practice:

The County has a long way to go in order to address the needs of disabled children in a unified, multidisciplinary holistic way... social workers have

become more professional - more professionally organised - but I have not observed that this has really impacted on service provision.

Most questionnaire and interview respondents had witnessed the developments and reorganisations in social work services that had taken place over the previous decade in the locality, which were mentioned in Chapter 8 - these being, the reorganisation of social work from generic to specialist teams, leading to teams dedicated to children's services; the development of family-based respite care for children with severe learning difficulties; the establishment of the multidisciplinary team for children with severe learning difficulties; the development of specialist child protection teams; and the creation of unitary authorities. This last change in 1996 was followed by another reorganisation of children's services, in which the child care social workers took responsibility for all casework beyond investigation concerning children on the child protection register and for children accommodated by the local authority.

Despite questionnaire respondents having an average of 18 years in practice, more than half provided no response to the question about change in social work. Several respondents gave tentative answers preceded by reservations, such as 'probably...', or 'this is very subjective but...' Most comments did not reflect their 18 years of practice, although there were exceptions. For example, one health visitor, Mrs Q, wrote: 'My observation is that the services to children with disabilities and their families have improved ten-fold.' Another health visitor, Mrs S wrote: 'Social work has become more professional, and objective as a profession, but also much more threatened by litigation.' These comments suggest that the respondents were reflecting on change over a significant time. Generally, however, respondents tended to remark only on more recent changes, mainly since the Children Act.

Respondents did not mention 'care management' for disabled children. This could suggest that they did not know the Children Act or the Community Care Act sufficiently well to

comment on it. Nevertheless, several questionnaire respondents thought there had been some improvements in co-ordination and collaboration. Comments included, for example, 'Greater contact - more liaison and sharing of information'; 'More contact with individual social workers, more liaison' and 'Probably improvement - more involvement of the social work group.' These remarks do not suggest that social workers have been taking a co-ordinating role, but they indicate some improvement in collaboration. The question of the care management role is examined further below.

In the context of all the changes mentioned above, the interviews revealed that the establishment of the multidisciplinary specialist team was the only development that respondents thought had made a significant impact on services for disabled children and their families. The following discussion explores what it is about this service that stands out for respondents.

Specialist service: the route to improving practice?

Where respondents commented on significant improvements in social work practice for disabled children and families they said that these related specifically to the specialist social workers. For example, among the interview respondents, Mrs W (teacher), Mrs K (physiotherapist), Mrs E, Mrs M and Mrs T (health visitors) all remarked on the valuable contribution made by these social workers. Another health visitor, Miss K, wrote in her questionnaire that:

The specialist team (and the social work contribution to that) has led to improvements; also closer liaison with the hospital social worker in the past year has improved co-working.

Another health visitor, Mrs D, expressed a similar opinion that the specialist service had improved practice:

Resources for children with disabilities are never sufficient. Problems and planning for the future of these children are discussed at team meetings. The role of the social worker is working within the multidisciplinary team, and with the parents, so the child reaches his full potential.

However, several respondents, including members of the team themselves, commented on the limitations of what the team could achieve alone, and without extra staff. Mrs P (health visitor) emphasised the importance of the specialist team for those children and families who received the service. However, she thought that:

The service must develop to provide for physically disabled children - despite reorganisation and new legislation such developments are very slow, and local planning has been start-stop, start-stop.

Mrs P and Mrs E (health visitors) considered the child care teams too focused on child protection, and they did not expect this to change in the foreseeable future. They both thought that improvement could be achieved if the specialist team were strengthened with extra social workers and if the team extended its remit to provide a service to more disabled children.

Mrs J (health visitor) suggested that, despite legislative changes, progress was very slow in social services. She considered that the development of the specialist team was constrained by shortage of funds and resources, which led to narrow eligibility criteria for services, which in turn excluded a lot of disabled children.

Mrs B (community nurse) thought that the lack of development of social services for disabled children provided evidence of the department's unwillingness to 'recognise the true level of clients' needs'. She considered that this reflected a lack of commitment to disabled children and families. Mrs B thought that the department had neglected opportunities to work closely with health agencies and, while the department had conducted surveys on the needs of families, there was little evidence that the findings had been acted on. Mrs B judged that while

employment conditions had improved for social workers in recent years, there was little evidence of service improvement for clients.

Everything 'sounds' better, but the service is no better - including the specialist team - what we should be offering and what we do are wide apart... Things seem to improve for staff, but not for clients, which is very annoying - it makes it difficult for relationships with clients. (Mrs B.)

Mrs E and Miss N (health visitors) observed that while child protection services had improved significantly in recent years, social workers were now rarely involved with disabled children unless there were child abuse issues.

Considering these comments, the following discussion examines what it is about specialist social work that respondents perceive to be of value in improving practice.

Respondents' views on specialisation

The views of some of the interview respondents were helpful in clarifying what it was about the specialist component of social work that they perceived to have led to improvements in practice and collaboration.

Specialisation was thought to require some in-depth knowledge about specific physical and intellectual impairments, particularly concerning those conditions that are more common and severe. Respondents also considered it necessary for specialist workers to have knowledge about the impact of specific conditions on children's behaviour, as well as the potential reactions of siblings, peers and people in general to this behaviour. This being particularly so regarding children with autism or hyperactivity disorder, whose behaviour may be challenging and stigmatising. Respondents also thought that specialist workers needed understanding about how disability can cause children and other family members to become isolated and excluded from

normal social experiences and life opportunities - and how the stresses and strains of caring can lead to family and marital breakdown.

The comments of many respondents demonstrated that for them specialisation meant that workers' caseloads would be dedicated to disabled children. In this way they would develop the specific knowledge, skills and insights required to work with disabled children and families - that is, through experience and multidisciplinary working.

Although several respondents thought that social work services for disabled children should ideally be integrating within mainstream child care services, they considered this unlikely to come about. Thus, observing that social work services to disabled children had improved since the specialist team was established, they considered that further improvement could best be achieved by increasing the social work staffing within the team, and by broadening the team's remit to include more children.

Better Services

Some respondents commented on other improvements that they had witnessed in social work practice. One health visitor recorded on the questionnaire 'More social workers involved now, but this is only an impression.' Another health visitor remarked that she was 'Aware of some new social work staff.' Mrs G, a health visitor, recorded an opposite opinion.

There have been improvements in liaison, but it seems that recently the number of social workers has been reduced which makes it more stressful and difficult to liaise so well.

Mrs P, a health visitor, expressed sympathy for child care social workers who she perceived to be overburdened by their workloads. She valued the specialist social workers for having the time available to visit and support families coping with the needs of more severely

disabled children. She suggested that these social workers should do more to advertise their resources and achievements.

Five questionnaire respondents considered that social workers involved families more in decision making than they used to. For example, parents were now invited to child protection case conferences. One health visitor, Mrs D, commented that greater consideration is now given to children's needs in social work. She thought that previously social workers only considered the needs of parents and carers. Another health visitor, with thirty years' experience, judged that:

Attitudes have changed dramatically. Every effort is made for children to remain with their parents, and problems are dealt with at home. The sick and disabled are cared for within the home, and use is made of day placements whenever possible. Children with special needs now have their needs met at home and within their own community. (Mrs H.)

However, respondents' remarks about improvements were greatly out-weighted by their perception of declining standards in social work practice. One respondent stated her view of:

The decline of social services in general, mainly because of pressures that both health services and social services are under. Also social workers change jobs very frequently, so its difficult to build up a rapport. Team working and liaison was better when professionals knew each other more (Miss J).

Other questionnaire respondents expressed similar views. Their remarks indicate concerns in three main areas: resources, staffing and practice.

Respondents suggested that social work intervention with disabled children was unsatisfactory because workers lacked the resources they required. One questionnaire respondent wrote: 'Lack of resources, shortage of staff and rapid turnover of personnel in the social work (children) department make this difficult.' Another questionnaire respondent simply wrote: 'Insufficient resources available to social workers.'

Eight questionnaire respondents, all health visitors, thought that there were insufficient social workers to cope with demand for services. Their comments included: 'Social workers overworked'; 'Social workers overloaded and stressed too much'; 'Shortage of staff'; 'Caseloads have increased'; 'Inadequate level of social work provision within teams given the lead role of the Social Services Department.'

Similarly, two health visitors, two teachers and several interview respondents perceived there to be a 'rapid turnover of staff' and 'frequent changes of social workers,' which they thought militated against good practice in supporting disabled children and families. They all thought that the Social Services Department should do more than they do to retain social workers.

Respondents considered that social work practice with disabled children had also declined in other ways. Four health visitors considered that the amount of communication, co-ordination and teamwork with social workers had reduced in recent years. Similarly, many questionnaire respondents judged that collaborative working could be improved if social workers communicated with them.

In the discussions in Chapter 3 concerning the social work role and responsibilities, the work of Sir Roy Griffiths and the introduction of the idea of care management through the Community Care Act 1990 were explored. The chapter identified that this role in assessing and co-ordinating services, including the interventions of other professionals - can have particular value for disabled children and families. Moreover, it complements the role described for social work in the guidance for practice under the Children Act 1989. Considering these matters, and in the light of their perceptions of social work competence generally, the researcher was interested in the opinions of respondents concerning social workers ability to fulfil this 'new' care

management - otherwise known as care plan co-ordinator or keyworker - role. The following discussion explores their responses of those professionals who were interviewed.

Care management: a role for social work?

None of the interview respondents seemed aware of the government's recommendations concerning care management for disabled children (as discussed in Chapter 3). However, they were aware that the government had emphasised the expectations on them to work more closely with other professionals. They did not demonstrate an awareness of the importance that legislation - the Community Care and the Children Acts - had placed on the co-ordination of the child's plan. Respondents did not refer to care plan co-ordination, except in relation to reviews undertaken at CDT meetings.

Questioning revealed that respondents did not envisage social workers taking a lead role in co-ordinating multidisciplinary interventions. They were uncertain about social workers' ability to fulfil such a role. They considered that a range of factors, including heavy caseloads, high staff turnover, and poor collaboration by social workers, prevented them from fulfilling such a role.

However, some respondents praised the keyworker system that operated in the specialist team - similar to the care management role - wherein families receive a named worker to assist with the co-ordination of services. They considered that this role could be fulfilled by any of the professionals in the team.

Some respondents also remarked on the keyworker role that they witnessed social workers fulfilling for children on the child protection register. However, they did not perceive

this as a 'care management role', but more as the co-ordination of the child protection plan for the period of registration only.

Mrs B (community nurse) considered that the 'most relevant professional', who she thought could be anyone with the relevant knowledge and skills, should hold the care manager/keyworker role. Her position is supported by the issues highlighted by Webb and Hobdell's (1980) model of the 'authority of relevance' (discussed in Chapter 2).

Similarly, Mrs A (community nurse) considered that:

It's about the skills to be able to co-ordinate and manage and liaise, and this is something in which I don't think social workers or nurses have an exclusive role... It's a new role, which social work and nursing training were not designed to equip people with the skills to do.

Mrs A considered that social workers were still trying to discover their role. She perceived them to be 'experimenting' with the new systems provided by recent legislation. However, she observed their development of the care management role to be greatly restricted by their focus on crisis intervention work.

The social workers that I do have contact with tend to spend a lot of time on crisis management, on placements breaking down and trying to find new ones - trying to sort that out and going from one case conference to another, apologising for the lack of action by their department. (Mrs A.)

Whereas the majority of respondents thought that care management was a role that social workers could conceivably fulfil, despite the uncertainties and reservations expressed above, they had not seen this being done. All the teachers thought it a good idea that one professional should co-ordinate all interventions. However, the primary school teachers thought that the role was not necessarily one for social work, and that an extension of the multi-professional keyworker system operating within the specialist team would serve as well. The secondary school teachers all remarked that the care manager/co-ordination role was not at all in evidence.

Several respondents suggested that while they perceive social workers to be equipped with the skills required for care management for disabled children, their potential in undertaking this role was adversely affected by staff shortages. For example, Mrs M (health visitor) said ‘There are insufficient social workers to respond to demand - even for families in crisis.’ Mrs K (physiotherapist) also thought that social workers were restricted by their heavy workloads. Commenting on the care management/keyworker role she said:

When it works well it takes a load off me - it means that I can concentrate on that part of the service that I am providing. Yes, it’s really helpful to have one person who has this kind of overview of the child’s needs - some social workers would do that better than others... Some are more easily contactable than others for some reason or another, I don’t know quite what that is. Whether it means that they have such a heavy caseload that they are rushing here and there, and you just can’t get hold of them. (Mrs K.)

Similarly, Mrs A (community nurse) thought that unreasonable management expectations, reflected in unmanageable workloads, prevented social workers from undertaking ‘preventative work’ with families. Consequently, she perceived that social workers were only ever seen dealing with crises.

Other health professionals were less sure that social workers could take on care management, because their knowledge about disability was inadequate. Dr E thought that a social worker could do the tasks required only if they worked as a specialist in a multidisciplinary team and if they were ‘willing to learn from the others.’

Similarly, Dr P said that she was aware how social work had claimed to be best placed to take on the care management role, but she disputed this. She thought that social workers often lacked the knowledge necessary for child disability work, and that a nurse or an occupational therapist might better do the role.

Mrs T (health visitor) held a similar opinion. She remarked that her professional training gave her a medical background that equipped her with essential skills that a social worker would not acquire unless they were a 'specialist'. Miss N (health visitor) also expressed great uncertainty as to whether social workers could undertake care management. In her experience social workers did not appreciate the importance of sharing information and having 'in-depth' discussions with other professionals about the long-term objectives of their work.

In summary, health and education professionals differ in their opinions as to whether social workers could competently carry out the care management role. However, there was a general view that care management was not being done by anyone, although the Child Development Team and members of the specialist team were undertaking some aspects of the role. The respondents perceived the potential for social work to fulfil this role - which, as Chapter 3 demonstrated, is at the heart of good practice in social work - to be restricted by social workers' lack of appropriate knowledge in child disability work, their lack of skill in collaboration, and the pressures of their workload. However, potential to fulfil this role was evident in the work of the specialist social workers, who were perceived to have been able to overcome these practice weaknesses and collaborative difficulties because they specialised and held a dedicated caseload.

The final discussion of the survey findings entails an exploration of respondents' views concerning the impediments to effective interprofessional collaboration between themselves and social workers. Questionnaire and interview respondents were asked to state what they perceived to be the most significant barriers to collaboration and what action they perceived necessary to remove them.

Barriers and solutions

Many questionnaire respondents provided examples of barriers to collaboration without proposing any solutions. However, for many of the difficulties mentioned the solutions were self-evident. The following serve as examples, 'Need for clear criteria/guidance about how requests for more resources should be made'; 'too much planning, not enough action'; 'insufficient social workers to respond to demand' and 'weak links between social workers and schools/Social Service Department and Education Department.'

The barriers that most respondents cited as restricting collaborative working were perceived to fall into two main areas: inadequate resources, including staffing, and practice weaknesses. Many respondents linked these issues in a chain of cause and effect. This was summed-up by one respondent who wrote: 'Shortage of staff = large caseloads = pressure of work = more staff needed.' The following discussion explores the views of questionnaire respondents about the problems in these two areas.

Inadequate Resources

Several questionnaire respondents were critical of social services management for inadequacies in services for disabled children and families. For example, one respondent recorded:

At field worker level I enjoy good working relationships with local social workers, sharing the usual frustrations regarding resource shortages. At more senior positions there seems to be a different underlying philosophy of care and different priorities (Questionnaire respondent).

Others recorded similar frustrations, such as 'Insufficient funding to implement recommendations made for disabled children e.g. for child to attend a local playgroup' and 'Social Services Department failing to recognise true level of client need.'

These barriers to effective collaboration were also mentioned by interview respondents, who were disappointed at what they perceived to be a weak commitment to disabled children and families on the part of the Social Services Department. Although it was not always clear what they meant by 'commitment', the solution they proposed was that the Department should increase resources, rather than encourage individual social workers to change their practice.

The resource that respondents considered needed increasing most was staffing. More than half the questionnaire respondents (24) thought that staff shortage impacted on collaboration with social workers. One health visitor wrote: 'Lack of resources - the number of social workers - means that lower priority is given to children with disability on social workers caseloads.'

Mrs J (health visitor) considered that there 'never seems to be the commitment' from the social services to collaborating in the effective multidisciplinary working of Primary Health Care teams. She suggested that that there needed to be less 'them and us' between health and social care agencies and professionals. She thought this could be achieved if social workers were involved in Primary Health Care teams. Several other health visitors suggested that having an social worker attached to GP practices would facilitate multidisciplinary working and help overcome barriers to collaboration.

Practice weaknesses

Many respondents, health visitors in particular, expressed some sympathy for social workers who they perceived to be carrying complex caseloads and facing many constraints on their ability to meet clients' needs. They viewed these unrealistic demands as militating against social workers doing the quality of work they wished to. This perception suggests a certain 'solidarity' with social work from these other professionals, which may arise because they face

similar pressures to those that they perceive social workers to be under. However, it may also be that these respondents were reluctant to presume to make judgements about how social workers should organise themselves to improve practice. Blaming poor management commitment and inadequate resources may be an easier answer, with a clearer solution, than criticising social work for failing to address poor professional standards.

However, other respondents were keen to point out what they saw as organisational or professional weaknesses in social work. Four themes emerge from respondents' remarks about how practice weaknesses can create barriers to collaborative working. The first is social workers' lack of understanding about other professionals' roles. The second is social workers not doing enough to explain their role. Third, there is social workers' lack of understanding concerning the needs of disabled children and families; and finally there is poor social work intervention. Many of these weaknesses have already emerged from the discussion of the survey findings thus far. Respondents made two main proposals about how these frequently witnessed problems could be tackled. The first involved training, the second concerned the profile of social work.

Regarding the importance of training, Mrs N, (questionnaire respondent), perceived that 'Social workers have a narrow perception of others' roles, and are reluctant to accept other professionals' assessments.' She proposed that social workers needed training about the roles and contributions of other professionals. Several interview respondents also considered that social workers needed to learn more about the contributions of other professionals, and that they should have training in collaborative skills such as liaison and collaboration in planning. One questionnaire respondent commented that 'Social workers should be taught how to give information.' (Mrs H). Another respondent, Miss D, suggested that experienced social workers

should attend other professionals' training courses to explain their role and provide examples of case studies.

Those respondents who perceived social workers to have a narrow perception of others' roles and a reluctant to accept others' assessments, thought that social work training should devote more time to considering the contributions of community nursing, health visiting and occupational therapy. One respondent, Mrs V, thought that the barrier of 'professional territoriality' could be broken down quite effectively if social workers were clear about their role and understanding and appreciative of the roles of others.

Many respondents expressed concern about how poor communication from social workers affected collaborative working. The following sample of comments were recorded as barriers by questionnaire respondents: 'Poor communication'; 'Poor information-sharing'; 'Referrals not followed-up'; 'Feedback not given'; 'Communication dwindles unless there is a crisis'; 'Social workers ask for information regarding families, but rarely feedback'; 'Need more effective liaison' and 'Other professionals sometimes left out of meetings and planning for children.' Respondents again proposed that training would provide a solution to these difficulties - that is, training that addresses the importance of good communication, multidisciplinary working, and respect for others' roles.

Regarding the profile of social work, each of the paediatricians and several of the teachers interviewed, said that social workers needed to address both their public and professional profile. The important of this was stressed for two reasons: first, because of families' perceptions of what social work is about; and second, because of the need for social workers to educate other professionals about their role and to publicise their achievements.

Dr H (paediatrician) said that ‘The outlook of most patients at the suggestion of a social worker is of an imposition on them - until they’ve come to know the social worker.’ Dr E (paediatrician) also pointed out that it was not uncommon when she suggested social work assistance to parents that they would express alarm and say ‘We don’t need a social worker!’ Dr E compared this rejection to that of someone to whom it is suggested they should see a psychiatrist ‘I don’t need a psychiatrist, I’m not mad!’ Dr E remarked that just as psychiatrists do not deal only with people whose mental health problems have the gravity of madness, so too social workers do not deal with just child abuse. However, she perceived that ‘Families need to know what a social worker does, otherwise they are concerned about it.’

These responses confirm that other professionals assume that parents can feel uncomfortable when confronted with the possibility of social work input, either because they have little choice about whether they want it or not, as in child abuse cases, or because they have a preconception that social workers are by their nature imposing or intrusive. The paediatricians suggest that once parents get to know what social workers are really like and what they can do to help, then they are accepting of them.

Similarly, other respondents considered that parents associate social work intervention with having ‘family problems’, and consequently they are fearful of being stigmatised by social work involvement. However, several respondents perceived that, other than the specialists, social workers only do get involved when there are significant problems - that is, that they are not available for supportive or preventative intervention. This perception was reinforced for them by the fact that they rarely ever witnessed social work intervention outside of the child protection arena.

Conclusion

The survey responses explored in this section demonstrate how, despite major changes in legislation that heralded a new collaborative approach to social care, health and education professionals perceive there to have been little improvement in the social work approach to collaborative care for disabled children. Where improvements have been observed they are credited to a few specialist social workers. However, respondents do not consider this to be enough. The social services agency is accused of neglecting their responsibilities and lacking commitment to disabled children and families. Respondents perceive that this manifests in the inadequate resources and insufficient staff dedicated to this field of work. Because they witness social workers to be over-burdened by heavy caseloads and child abuse work, they cannot conceive of their fulfilling a lead role in the co-ordination of care plans for disabled children.

However, the blame does not fall wholly upon the shoulders of the social services agency, social workers too are seen to be failing in the standard of their practice in key areas. These include some basic skills in communicating effectively with other professionals, and in understanding the contributions that others make to child and family welfare. These criticisms do not seem confined to the field of child disability, although effective communication has been witnessed where collaboration is necessary in co-ordinating child protection plans. In this area of social work - child protection - there is a suggestion of social work potential to overcome collaborative difficulties. However, more substantial potential is evident in the work of the specialist social workers, not only to overcome collaborative difficulties but also to improve practice in child disability work. The survey demonstrates, however, that if this potential is to be fulfilled, if good practice is to be extended, those successful elements of the specialists work need extending.

The overall conclusions that can be drawn from this chapter for the researcher's thesis concerning social work's potential are discussed in the next chapter, which concludes the dissertation.

Chapter 9 - Conclusions

Introduction

In examining the nature of the relationship between social workers and other professionals, with particular reference to collaborative working with disabled children, this thesis has explored the difficulties affecting collaboration and considered how they are constructed and maintained, and how they might be overcome.

In the literature review existing explanations were identified for the problems affecting social work practice with disabled children, including the collaborative difficulties between social workers and other professionals. The review prompted the researcher's thesis that social work has the potential to overcome the difficulties of collaboration and its own practice weaknesses. The review then informed the design of the questionnaire and interview schedules, which have been used to test this thesis and to discover whether the collaborative difficulties and practice weaknesses, and explanations for them, were similar to those identified in other contexts and localities.

The research findings in Chapters 7 and 8 have critically examined the thesis by exploring the roles and assumptions of social workers, and the views and opinions of social work among fellow professionals who work with them in children's services. This concluding chapter considers the weight of evidence for and against the thesis based on the insights gained from the survey of professionals. The discussions are organised in two sections: overcoming collaborative difficulties and overcoming practice weaknesses. Hornby's (1993) framework, as discussed in Chapter 2 - which emphasises the importance of taking both a relational and structural approach to collaborative problems and of appraising skills, training and resource needs at interpersonal,

interprofessional and interagency levels - is utilised in discussing those factors that the research suggested could impact most on social work potential in collaborative working.

Section 1: Overcoming Collaborative Difficulties

The review of the literature identified that there were many wide-ranging explanations for relationship difficulties affecting collaboration between social workers and others. These included others' uncertainties about the competence of social workers, the semi-professional status of social work, stereotypical views of social workers, lack of understanding between professionals concerning their roles and contributions, assumptions of medical leadership in disability work, and weaknesses in the structures for service delivery.

The thesis argued that social workers are capable of overcoming these difficulties. The researcher based this assertion on the hypothesis that social workers have the skills with which to effect interprofessional collaboration. However, an important distinction was drawn between the possession of these skills and social workers' ability to use them convincingly in a leading role in the field of child disability. This distinction needed to be drawn because it was identified in the literature that many difficulties in collaboration were associated with professional status, for instance problems could arise if the education and training of an occupational group was not perceived to be credible as 'professional' by others. Thus, for social workers to overcome many of the collaborative difficulties the literature suggested that they might need to achieve recognition as 'professionals'.

The survey explored different aspects of these matters through various lines of questioning. Chapters 7 and 8 provide evidence that each of the collaborative difficulties mentioned above seemed to be present in the locality of the research, and for much the same

reasons as other commentators had found in other localities and contexts. The following discussion of conclusions will concentrate on examining the evidence of the survey, relating first to whether social workers have the skills to effect collaboration; second, whether they are able to use them convincingly in a leading role, and specifically in child disability work; and third, whether their abilities to overcome collaborative difficulties arise from a recognition of their 'professionalism'.

Skills in collaboration

The survey of social workers revealed among practitioners the sort of personal 'attitudes' favourable towards interprofessional collaboration, which had been identified as necessary in Chapter 2 (Hornby 1993; Loxley 1997). Importantly, at the interpersonal level, social workers wanted to work closely with others; and there was definite evidence of their use of collaborative skills, particularly in crisis intervention, child protection, and the work of the specialists. However, other professionals were generally critical of social work skills in collaboration. By and large, they experienced social workers to be poor communicators, who did not understand or respect their roles and contributions. They expressed pleasant surprise if the social worker turned out to meet their expectations.

The survey findings highlighted in Chapter 7 revealed that the social workers, without exception, stated that their qualifying training had failed to adequately equip them for work with other professionals. Moreover, they considered there to be insufficient opportunities for them to address this (with regard to collaboration in the care of disabled children) through post qualifying training. Thus the difficulties in collaborative working, which were apparent in their personal and professional relationships, were accounted for somewhat by organisational weaknesses in

respect of training. The conclusions drawn at the end of Chapter 5 provide further discussion of the significance of training and continuing professional development in the fulfilment of social work potential in collaborative care.

Skills used convincingly

The example of child protection provides evidence of ability among social workers to make effective use of certain collaborative skills. Moreover, in child protection these skills are used in a highly complex and risk-laden field of work.

The discussions in Chapter 4 suggested a significant contrast between child protection and child disability work. The public attention given to child protection, and the serious implications of adverse publicity and shame if reports of abuse are not expertly investigated, lead social workers and local authorities towards a mutual interest in ensuring that child protection is done well. There is much to gain for social work from child protection work being done effectively, and there is much to lose if it is not. Consequently, social workers prioritise child protection work so as to avoid criticism and the possibility of losing powers and authority in the future if the work is not efficiently undertaken. Meanwhile, local authorities prioritise investment in recruiting and training practitioners who can use the powers in a skilled manner.

When resources are directed towards the main priority of tackling child abuse, it is often the case that a less than active approach is taken for disabled children (Middleton 1996). As discussed in Chapter 3, this situation may be rationalised by social workers because responsibilities for disabled children are shared with other statutory agencies, and thus services - schools and medical facilities - are already in place to which social work and social services may be viewed as supplementary, whereas in child protection the social services department and

social workers hold primary responsibility. There was evidence of this perspective in the comments of survey respondents.

The contrast between child protection and disability social work was accentuated further through survey respondents remarking on the substantial changes that have taken place locally in child protection practice in recent years, yet commenting little on changes in the organisation and provision of child disability services.

The changes that have taken place in child protection work are characterised by collaboration at interagency, interprofessional and interpersonal levels. These include the joint development of procedures for investigation and assessment, which require social workers to exchange information and to collaboratively with a wide range of other professionals. The processes of investigation and assessment require social workers to talk with children, to work in partnership with parents, and to consult other professionals. Planning requires social workers to convene conferences where decision-making is shared with other professionals, with the involvement of parents and children. The key worker role requires the social worker to co-ordinate information and services from different professionals as they contribute to the child's plan. Joint training supports this approach to practice for practitioners and managers. Finally, multi-agency committees review and audit practice to ensure that quality standards are met, and to recommend how continuous improvements can be achieved.

The construction and maintenance of these structures and processes have required social workers and their agencies to give a considerable commitment to professionalism in child protection. Furthermore, it has been necessary for social workers to develop the skills required to overcome or minimise the difficulties associated with collaborative working so that they can achieve successful joint working in assessment, decision-making and intervention. Thus, the

keys to fulfilling social work's potential and to convincing others of social work skills may be found in replicating in children's disability services the sort of commitment that has brought about many of these initiatives in child protection.

The discussions in Chapter 4 concluded that if social workers are to be consistent in their values and commitment to protecting all children from abuse, they would expect their agencies to commit similar resource investment to the welfare of disabled children as they give to child protection, including the provision of skilled workers, comprehensive training and interagency support for interprofessional working. It is further suggested that if social workers were committed to developing the same standard of service (the same level of expertise) for disabled children as is provided in child protection then this could lead to greater recognition of the skills of practitioners.

However, the survey of other professionals revealed that in most cases they do not perceive social workers using collaborative skills 'convincingly'. While these other professionals consider social workers' collaborative skills to be more in evidence in child protection than in child disability work, they nevertheless perceive them to be limited to the social workers' need to get what they want - that is, for others to fulfil specific tasks concerned with child protection. In doing so, others find that social workers demonstrate a lack of appreciation of their wider roles and contributions, and this militates against social workers' collaborative skills being convincing. Moreover, there is evidence that this lack of appreciation impacts adversely on interpersonal and interprofessional relationships between social workers and other professionals. The social workers' suggest that their lack of training in child disability social work and interprofessional working contributes to their general lack of confidence in collaboration and their ability to transfer skills from child protection to child disability work.

Leading role in collaboration in child disability work

The survey of social workers revealed that, with the exception of the specialists, most of the social workers interviewed lacked knowledge about child disability and this militated against their use of collaborative skills in the field. Furthermore, and again with the exception of the specialists, their minimal involvement in child disability work (and their absence from multidisciplinary arenas where the needs of many disabled children and families are considered), means that they have few opportunities to develop their confidence in child disability work, and hence they are unlikely to take a leading role. Moreover, the survey of other professionals revealed that they do not consider social workers sufficiently skilled to assume a leading role in care management/care plan co-ordination (with the exception of the specialists). In fact, they consider that many different professionals with skills in child disability work could do the task equally as well, if not better than, social workers. However, the survey also demonstrated that many of these practitioners consider their own knowledge about the social work role and what is distinctive about it to be inadequate. This highlights the importance of agencies collaborating in appraising and meeting the training needs of all participating professionals if the benefits of collaborative working practices are to be maximised and if the roles of different professionals are to be fulfilled.

Recognition as professionals

The evidence of the survey and the literature is that where social workers have been observed to overcome collaborative difficulties - in specialist child disability work, child protection and crisis intervention - others recognise them for this. The discussions in Chapter 4 established that recognition is a fundamental feature of status. The survey found that other

professionals perceive that social workers undertaking this work have pursued 'specialist' training, or at least gained a sufficient depth of experience and maturity to combine with their initial training, so that they know how to respond 'professionally'. This perception is largely based upon interpersonal contact between practitioners. However, there is evidence that other professionals do not generalise these positive relationships to social work more widely, neither do they seek to discover more about what social work has to offer. In fact, there is substantial evidence that other professionals do not generally understand the role and contributions of social work. They have narrow expectations of them and can perceive them as less than professional (as service gate-keepers, hand-maidens, resource procurers, super clerical officers, and benefits advisors). This emphasises again the important role that all agencies carry in promoting awareness of the social work contribution if the maximum benefits of collaborative initiatives are to be delivered.

Conclusion: potential to overcome collaborative difficulties

On balance it seems that the potential for social work to overcome collaborative difficulties in child disability work is weak. The survey has provided evidence of some social work commitment to collaboration, although it is rarely seen to go beyond information sharing, which is on social workers' own terms. However, there is evidence that social workers face constraints on their ability to do more in the way of collaboration because of heavy caseloads and a concentration on child protection work. Thus, arguably if they had less of a burden in this respect they would have more time to commit to collaboration. Social workers themselves argued that the lack of time available to them created one of the most significant barriers to effective collaboration. Furthermore, as concluded in Chapter 5, the lack of training for social

workers in interprofessional working and child disability work appears to restrict their potential in three key areas: the development of knowledge specific to interprofessional collaboration in this field of work; the application of theory and values in practice; and the discovery of new ways to understand and improve practice.

There is nevertheless evidence of commitment from a wide range of other professionals to collaboration with social workers. Those among them who have a wider understanding of the social work role (even though this may be restricted to the context of their own work) seem very much to want social workers to fulfil their role - and they want collaboration with social workers over this. They appear to value social work, despite seeing little of it in child disability work. Evidence of this is seen in their praise for the work of the specialists, and in their concern about the unmet needs of many families for emotional support, information and advice about services, counselling and benefits advice (though the social workers were not claiming to be skilled in this last area). Furthermore, these other professionals display some sympathy with the heavy caseload demands that child care social workers face and, considering this, they also perceive that one of the major obstacles to social workers improving collaboration is their lack of time. Hence, these findings demonstrate the potential for positive interpersonal and interprofessional relationships, which could be fulfilled if supported by the necessary interagency structures.

However, other professionals also suggest that social workers could use their time more effectively. Moreover, they present a wide range of other criticisms about social work skills in collaboration; these professionals consider that improvements in social work training could provide the remedy to some of this. Yet, their comments also suggest that individual social workers could do more to improve interpersonal relationships and to enhance the reputation of their profession. A summary of solutions that social workers could adopt to address specific

difficulties in interpersonal and interprofessional collaboration is provided in the tables at the end of Chapter 2.

To conclude, therefore, while there is some evidence of social work potential to overcome collaborative difficulties, there is less evidence that this potential will be fulfilled to any great extent without the investment of human resources - so that social workers can have more time for child disability work and for collaboration. Moreover, the potential is unlikely to be fulfilled without the improvement of training and practice opportunities to enable social workers to develop knowledge of others' roles and of interprofessional collaboration. This conclusion supports the assertions of the second and third hypotheses as detailed in Chapter 1.

Section 2: Overcoming Practice Weaknesses

The literature review identified a number of weaknesses in social work practice with disabled children and families. These included a lack of understanding of and a failure to meet their needs, a lack of commitment to disabled children by social workers and their agencies, discriminatory attitudes, and poor skills in collaboration. The thesis argued that social work has the potential to overcome these weaknesses. The researcher based this assertion on the hypothesis that social workers have the skills required to help disabled children and families in distinctive ways that other practitioners do not.

Again, an important distinction was drawn between social workers' possession of these skills and their ability to use them convincingly in a leading role in child disability work. This distinction needed to be drawn because it was identified in the literature that a key task within the social work role in child disability work is that of co-ordinating multidisciplinary care plans. The fulfilment of this task requires extensive interprofessional collaboration for which, as the

discussions in the literature review and above have demonstrated, the recognition or 'status' of social work as a 'profession' may be important.

The survey explored different aspects of social work practice in child disability work through various lines of questioning. As with the discussions above, these concluding remarks focus on examining the evidence of the survey, relating first to whether social workers have the skills for effective practice in child disability work; second, whether they are able to use them convincingly in a leading role; and third whether they have the commitment to professionalism necessary to overcome practice weaknesses.

Skills to help disabled children and families (in distinctive ways)

The survey of social workers revealed a limited awareness of the knowledge and skills required for child disability work and, in most cases, a lack of confidence in their ability to transfer existing knowledge and skills. Nevertheless, as discussed above, there was evidence of their ability to do this, to a certain degree, when necessary for child protection and crisis intervention.

The survey also demonstrated that social workers do not wholly understand the 'distinctive' contributions that they could make in child disability work. The particular contribution of the social model of disability was not mentioned as such, (although there was evidence of understanding the social work role in promoting social work and Children Act principles and values, which are consistent with the social of model of disability). However, despite the lack of understanding among social workers, there was evidence of skills and distinctive contributions in the work of the specialists - neither of whom had worked specifically in disability prior to appointment to their specialist posts, and neither of whom had received any

‘specialist’ training. Their example also provides evidence of social workers’ ability to transfer knowledge and skills.

The survey of other professionals revealed that they are not persuaded through either their personal contact or professional knowledge that social workers have the skills to help disabled children and families. However, the specialist workers again provide the exception to this.

Skills used convincingly, in a leading role

As stated above, the survey of other professionals revealed that they are not convinced that social workers as a rule have the skills for child disability work. Although these professionals witness the necessary skills within the specialists’ work - and they perceive that other social workers might respond effectively to the needs of disabled children if they were not so focused on child protection - they nevertheless do not envisage social work in a leading role. They do not perceive social workers’ contribution to be sufficiently skilled and distinctive to justify their claim to be best placed for care plan co-ordination/care management.

The survey of social workers found that they are not making any claims about having a lead role. The suggestion is that this is because they do not realise what their role and distinctive contributions might be, or the potential importance of them for disabled children and families. Arguably, some exception to this can be found in the specialists’ approach. However, despite highlighting certain distinctive aspects of their work, these specialists did not claim a leading role.

These findings highlight the importance of examining structural and relational factors in collaboration. Regardless of whether the social workers claim a leading role, or whether other professionals perceive them as having such a role, the role that social workers possess is indeed a

leading one. The evidence of the survey is that social workers fail in their interpersonal and professional contact to convince others of this leading role because they are inadequately supported in taking the lead by their agency – that is, in order to lead they require adequate structures, sufficient resources, advanced training and clear interagency agreement concerning multidisciplinary work practices.

Social work ‘commitment to professionalism’

The issue of social workers’ commitment to professionalism was not directly explored with either the social workers or other professionals. However, some conclusions may be drawn from the survey findings by reference to the discussion of ‘commitment to professionalism’ in Chapter 4, which was based mainly on the writings of Butrym (1976).

Butrym asserted that a commitment to professionalism was necessary for social work for two reasons. First, because social workers are exercising expert judgement in complex and risky situations; and second, because social workers give a serious and responsible commitment to providing a regular service in response to expectations: Butrym called this ‘giving of one’s best.’

The evidence from the survey is that both these features of a commitment to professionalism are evident in the work of the specialists. This is seen in the fact that other professionals turn to them for help - to provide expertise - over complex and risky situations that arise for disabled children and families. Moreover, the specialists intervene in a range of such situations (including domestic violence, alcohol abuse and concerns for the welfare of children). Furthermore, the survey found that their responses meet with the expectations of other professionals.

However, while other social workers are perceived to fulfil these features of a commitment to professionalism within their child protection and crisis intervention work, they are not seen by other professionals to be making a serious and responsible commitment to providing a regular service in response to expectations for disabled children and families. The evidence from the survey is rather that there is some avoidance of child disability work by these social workers. The discussions in Chapter 3, (Browne 1982; Middleton 1996), and Chapter 7, (survey results), suggested that there might be various reasons for this avoidance of child disability work. It is difficult to draw conclusions from the survey sample, and this might usefully be an area for further research. However, in this research the main reasons why social workers seemed to avoid child disability work were their lack of confidence in their knowledge and skills for this work, and their attempts to reduce or prevent excessive pressure on their workload.

Both these matters demonstrate how social work performance can be inextricably linked to their relationship with their agency. These are matters for the agency to grapple with, because the social workers' inability to make a serious and responsible commitment to disabled children arises in part because the priority focus of their workload is on child protection. Thus they are 'giving of their best' in another direction. While this work may be very important, the approach only admits disabled children where there is child abuse (or perhaps when there is a crisis). Otherwise, the approach - the structure of the service - excludes disabled children and families. Thus, the survey results suggest that it is necessary for the agency to make a commitment to professionalism in social work, and for this commitment to be demonstrated through ensuring that organisational structures enable social workers to provide a high standard of service to disabled children and families (as discussed in Chapter 3).

The survey also revealed that the lack of confidence among child care social workers, combined with a perceived lack of resources and their heavy caseloads, caused them to give the impression of a degree of powerlessness, as far as disabled children were concerned. However, despite some unhappiness about this, the researcher did not get the impression that these social workers were challenging their agency over these matters. Arguably, such a challenge would be characteristic of a 'commitment to professionalism.'

Conclusion: potential to overcome practice weaknesses

On balance it seems that the potential for social work to overcome practice weaknesses in child disability work is weak. The evidence of the survey of other professionals concerning the work of the specialists is that social workers can transfer knowledge and skills to help disabled children and families in important and distinctive ways - ways that perhaps other professionals would not be capable of achieving. This was the assertion of the second hypothesis. However, the research concludes that the generalisation of the necessary skills requires a 'commitment to professionalism' in child disability work from social workers more widely and from their agency. The evidence of this research suggests that the achievement of professionalism in this field (and arguably in other areas of social work) requires both the separate and collaborative efforts of social workers and their agencies.

The discussions in Chapter 4 concerning professionalism demonstrated that ultimately, most of the power lies with the agency. Thus, social workers may complain or make demands on their managers. They may strive to achieve high standards in their own work. Their representative bodies may claim professional status for them and assert that they have the appropriate training and skills to fulfil a leading role, but without the commitment of the agency

to provide practical and human resources, training and practice opportunities, appropriate structures, services and procedures, then social work's 'professional' performance in such areas as child disability, and the potential of social work in interprofessional collaboration will remain unfulfilled.

To finish on a forward looking and positive note, as argued in the conclusion to Chapter 5, the work of the National Assembly for Wales, the Care Council for Wales and the Training Organisation for Personal Social Services to develop care standards, to improve the quality and 'professionalism' of the social care workforce, and to increase practitioners' opportunities for continuing professional development may provide new opportunities for the realisation of social work potential and for the improvement of services for disabled children and their families.

INTERVIEW GUIDE

HEALTH AND EDUCATION PROFESSIONALS EXPECTATIONS OF SOCIAL WORKERS IN INTERPROFESSIONAL COLLABORATION REGARDING DISABLED CHILDREN

Section A: The Respondent's Work and Organisation

1. Job title
2. Profession
3. Qualifications
4. Years qualified
5. Service / Agency
6. Clients
7. Team
8. Team Members
9. What role does the respondent have for disabled children? What do they offer which is particular to their profession? How do they differentiate their role from social work?
10. What forums do they attend for multidisciplinary planning, service provision and development?

Section B: Collaboration with Social Workers

11. Which Social Workers do they have contact with?
12. What is the nature and frequency of this contact?
13. What is their attitude to close liaison or co-working with social workers?
14. Do they find that social workers understand their role and professional training?

Section C: Knowledge and Views of Social Work

15. What does the respondent know about social work training?
16. The qualification?
17. The duration of study, the time spent in placement etc.?
18. What do they consider to be the main elements of social work knowledge and skills?
19. What opinion do they have of social work skills in special needs?
 - explore their views on social worker's knowledge in special needs e.g. types of disability and their affects upon the child's development ;
 - explore their views on social work skills in liaison and collaboration, organisation and presentation;
 - explore their views on social worker's explicit use of theory and philosophy to inform practice.
20. Ask the respondent to state the social work role, and to describe the 'Ideal Social Worker' - ask them what they consider the social worker's 'unique' or 'particular' contribution to be.

- 21-25.** Invite the respondent to speak about the components of their training that have addressed the social work profession, and collaborative working.
- 26-27.** Has the respondent had training on (or studied) recent legislation or policy documents ?
- 27+.** Ask the respondent to give their views about social workers acting as case managers in co-ordinating the services of all other professionals involved with a disabled child and family.
- 28-29.** Ask the respondent whether they have witnessed any changes in social work practice as a result of policy changes, including local reorganisation;
-and whether their expectations of social workers have changed as a result
- 30.** Invite respondent to speak freely about any problems they experience in collaborating with social workers, and on how to resolve them.

INTERVIEW GUIDE

SOCIAL WORKERS VIEWS OF THEIR OWN ROLE AND OF INTERPROFESSIONAL COLLABORATION REGARDING DISABLED CHILDREN

The Respondent's Work and Organisation

- 1 Job Title.
- 2 Profession.
- 3 Professional qualifications.
- 4 Year of qualification.
- 5 Service.
- 6 Clients.
- 7 Team.
- 8 Team Members.
- 9 & 18 What role does the respondent have for disabled children?
 - a. Employment
 - b. Professional.
- 10 What forums do they attend for multidisciplinary planning, development and service provision?

Particular Contribution to the Child Care/Treatment Plan

- 9+ What do they offer that is particular to their profession, (which others might primarily expect the social worker to contribute)?

Knowledge and Experience in the Field

- 18 & 19 Ask respondent about their specific knowledge in the field of disability; their use of theory and research findings; their understanding of the main elements of social work knowledge and skills, and the principles which guide their work.
Has respondent had previous work experience specific to children with special needs?
Ask if they have enough training in special needs and how their needs are identified and met (e.g. Supervision).

Focus on Others' Roles and Collaboration during Training

- 21-25 Invite respondent to speak about the components of their training (qualifying and post-qualifying), which has given them knowledge of other professionals' training, skills and roles; and of collaborative working.

Experience of Collaboration with other Professionals

- 11-13** Invite respondent to talk about their experience of interprofessional collaboration. With who do they collaborate and how?
- 14** Do they feel that others are knowledgeable about their role and skills?
- 18 & 19** Explore what they feel about their own skills in collaboration and presentation of their work, and how they think others view them and their contribution.

Ideal Social Worker and Unique Contribution

- 20** Ask if the social worker has any particular or unique contribution to make.
Ask the social worker to describe the 'ideal social worker' (compare to real social work).

Effect on Collaborative Working as a result of recent Policy changes and Local Reorganisations

- 26** Has the respondent had training on or studied recent policy documents?
- 27** Ask their views on co-ordinating services, including those of other professionals (care management).
- 28 & 29** Do they feel that expectations on them have changed as a result of policy changes?
- Have they changed their practice as an outcome of policy and local reorganisation?

Barriers to Effective Collaboration

- 30** Ask respondent to speak freely about barriers and how to overcome them.

Any Other Views

(Is it the respondent's view that a specialist social worker should take on casework with disabled children.)

Notes:

There are no comparable questions for 15, 16 or 17.

QUESTIONNAIRE CONFIDENTIAL

CHILDREN WITH SPECIAL NEEDS EXPECTATIONS OF SOCIAL WORKERS

The researcher invites you to share your views and experiences of collaborative working with social workers that are involved in the planning, co-ordination and provision of services to children with special needs.

Your views will be used to develop an understanding of professional expectations on social workers, working within the structures provided by the Children Act 1989 and the Community Care Act 1990.

Your assistance in this will be used to inform social workers as to how high standards of interprofessional practice can be achieved for children with special needs and their families.

Your contribution is much appreciated, I thank you for taking the time to participate and I look forward to receiving your views.

Researcher: Michael Catling B.A., Dip PSW (CQSW)

A. ABOUT YOUR WORK AND THE ORGANISATION YOU WORK FOR.

1. What is your job title?
2. What is your profession?
3. What professional qualifications do you have?
4. For how many years have you been professionally qualified?
5. What organisation do you work for?
6. With which of these client groups do you work?
(Please tick as appropriate).

Children

Children in need (but who are not disabled)

Children with learning disabilities

Children with physical disabilities

Children with visual impairment

Children with hearing impairment

Children who are ill and/or in hospital

Children and families

Please put a circle around the group above, with which you spend most of your time.

7. Please name the team(s) within which you work.
8. If your team is multidisciplinary, please list the other professionals with whom you are working.
9. What tasks do you undertake within your professional role for children with disabilities?
10. Which meetings do you attend for multidisciplinary planning for individual children and families, or for service/professional development?

Individual Children: -

Service Development: -

Please indicate with a tick those meetings that you also use for liaison with social workers.

B. COLLABORATION WITH SOCIAL WORKERS

11. In carrying out your work for children with disabilities, with which other teams and services do you liaise where social workers work.
12. How many hours a week do you spend in direct liaison with social workers i.e. meetings, face to face discussions or telephone contact relating directly to work with a child with disabilities and their family?
13. Do you have liaison with social workers regarding the following?
Please tick the appropriate column.

	OFTEN	SOMETIMES	NEVER
Undertaking specialist Assessments.			
Providing specialist services to the child/family.			
Requesting or giving specialist advice.			
Opportunities to share information about each other's work with the child/family.			
Working together in preparing a child's individual plan. (Child Care Plan).			
Having a multi-disciplinary/multi-agency meeting to prepare a child's individual plan.			
Working together in implementing the plan.			

Working directly together in meeting the child and family's need (i.e. co-working).

Working together in evaluating the plan.

14. (Please circle the appropriate responses)

a). In your contact with social workers do they have sufficient knowledge about your role and the particular contribution you make within a child's plan?

Wholly Insufficient Insufficient Sufficient Impressive

b). Do you feel that social workers have sufficient understanding about your professional knowledge, skills and value base?

Wholly Insufficient Insufficient Sufficient Impressive

c). Do you feel that social workers have sufficient understanding about your professional training?

Wholly Insufficient Insufficient Sufficient Impressive

C. KNOWLEDGE AND VIEWS OF SOCIAL WORK

15. What is the basic professional qualification for social workers? (Please state).
16. How long is the training period for achieving the qualification?
- Do you consider this to be sufficient? Yes/No
17. Do you know what sort of additional training social workers can undertake after qualification? Please state.
18. What are the areas of knowledge and skills which you consider essential for social workers providing services to children with disabilities and their families? Please state.
19. Are there any areas of knowledge and skills which you consider essential, but which are insufficiently contributed by social workers? Please state.
20. Do you consider that social workers have any unique contributions to make? If yes, please give details.

21(i). Did your qualifying course address the role and contribution of the social work profession? Yes/No.

(ii). If yes, how was this achieved?

22(i). Have you had opportunities to examine the role and contribution of social workers during your post-qualifying training? Yes/No

(ii). If yes, how was this achieved?

23. To what extent has your training examined multidisciplinary working and interprofessional collaboration in child care. Please circle.

Not At All

Insufficient

Sufficient

In Detail

24. What have been the main sources of information for you about social work?

25. Please circle the appropriate responses: -

- a). Do you feel that you have sufficient knowledge about the role and particular contribution which social workers make within the planning and provision of services to children with disabilities and their families?

Wholly Insufficient Insufficient Sufficient Comprehensive

- b). Do you feel that you have sufficient understanding about social workers' knowledge, skills and value base?

Wholly Insufficient Insufficient Sufficient Comprehensive

- c). Do you feel that you have sufficient knowledge of social work training?

Wholly Insufficient Insufficient Sufficient Comprehensive

26. What training have you received on The Children Act 1989 and The Community Care Act 1990? Please state.

27. Have you had training, or undertaken any study into the expectations of the above legislation, specifically regarding children with disabilities? Yes/No

28. Whilst you have been in professional practice have you observed any improvements or any decline in social work knowledge, skills and practice in the planning and provision of services to children with disabilities and their families? Please comment.
29. Have you observed any changes in social work practice for children with disabilities as a direct result of The Children Act 1989, the Community Care Act 1990, or as a result of any other policy directive or local initiatives?
Please state.

D. EFFECTIVE COLLABORATION

30 (a). Do you consider there to be any failings within the social work profession, or social service provision, which leads to barriers which restrict effective interprofessional collaboration from taking place in meeting the needs of children with disabilities? Please state.

(b). Have you any suggestions for how these might be resolved? Please state.

Any additional comments that you would like to make would be most welcome.

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE

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